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**Exploring Evaluation in Practice from the Perspective of Public  
Health and Health Professionals: a Qualitative Field Study**

**By**

**Penelope Siebert**

**Thesis Submitted for Degree of Doctor of Philosophy**

**School of Health and Related Research**

**University of Sheffield**

**September 2014**

**This journey started because of the encouragement of**

**Doctor Corrine Camilleri-Ferrante**

**4 August 1954 – 20 March 2014**

**And**

**Dr Olivier Espinosa**

**20 October 1961 – 15 September 2010**

**Who are sadly no longer here to share in this achievement**

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---

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## **Acronyms**

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<b>AfC - Agenda for Change</b>
<b>CDC - Centre for Disease control</b>
<b>CVD - Cardiovascular Disease</b>
<b>DH - Department of Health</b>
<b>FPH - Faculty of Public Health</b>
<b>MRC - Medical Research Council</b>
<b>NSF- National Service Frameworks</b>
<b>NICE - National Intitule for Health and Care Excellence</b>
<b>PCT - Primary Care Trust</b>
<b>RCT- Random Control Trial</b>
<b>SHA - Strategic Health Authority</b>
<b>WHO - World Health Organisation</b>

## **Abstract**

---

### **Background**

There were concerns that robust evaluation of national public health programmes delivered locally was not being done, resulting in a lack of evidence to demonstrate the impact of programmes.

### **Methods**

A qualitative field study drawing on ethnographic approaches was carried out over 18 months in a Public Health department in a UK Primary Care Trust. Interview and observation data from 16 participants of varying roles and experience involved in implementing the NHS Health Check programme including programme documentary data was analysed using the constant comparative method to understand how evaluation was perceived and conducted in practice.

### **Results**

Participants' informal evaluation definitions encompassed different activities that formed an integral part of assessing the progress of the programme's delivery and implementation. Formal evaluation was defined as the processes required to produce reports for official scrutiny, demonstrate compliance with official targets, and provide evidence that programmes are delivered. Organisational structures, resources and expectations were instrumental in determining how evaluation was conducted. Evaluation in practice was observed to be predominantly retrospective, unstructured and focused on generating descriptive information about the programme's processes and progress. Participants devised their own multi-purpose and diverse evaluation procedures to meet personal, professional and organisational obligations to demonstrate success in some form.

### **Conclusion**

Limited use of recognised public health evaluation methodologies at local level was due to a mixture of operational, political and personal factors, including the desire to show success. The purpose of evaluation was to provide information to justify policy and financial decisions and to preserve services and jobs. Therefore the political and organisational structures and arrangements need to be in place to enable public health professionals to conduct robust evidence to deliver critical findings.

## **Section one: Thesis overview**

### **Chapter One**

---

#### **1.1 Introduction**

In recent years there has been a growing demand for public health professionals working in primary care trusts to provide information and evidence in order to demonstrate that public health programmes delivered locally are cost effective, improve health outcomes and reduce health inequalities (Department of Health 2010). Alongside policies and programmes to reduce health inequalities, there has also been a movement to develop a public health evidence and knowledge base to inform decision making and support policy development (Jenicek 1997). This growing emphasis on the need for evidence-informed policy and decision making to underpin public health practice has resulted in a number of frameworks and approaches aimed at improving the generation and use of evidence (Brownson et al. 2009), as well as guidance developed to support the evaluation of programmes (House of Commons 2009).

Evaluation was promoted as an approach that was integral for the generation of information to contribute to the public health knowledge and evidence base, as well as being important for providing the information for decision-making (Powles 2004, Des Jarlais et al. 2004).

Patton (1998) considers the evaluation of local programmes to be essential, as it was from these evaluations that meaningful information about programmes could be obtained. Evaluations of this sort have the potential to provide appropriate information for the development of effective policies, service development and decision making (Patton 1998), therefore understanding evaluation at a local level is important.

#### **1.2 The lack of robust evaluation of public health programmes in the UK.**

The lack of robust evaluation to demonstrate the impact and effectiveness of programmes delivered by public health agencies was a factor raised in a number of more recent reviews of the public health evidence base. These reviews examined the impact of policies and programmes

delivered to address health inequalities. The authors of these reviews concluded that there was little evidence available on the impact or effectiveness of public health programmes (Millward et al. 2003, Wanless et al. 2004, Petticrew et al. 2004).

Stame (2004) asserted that the evaluations currently conducted at local levels do not produce the kind of analytical information that policy makers and reviewers can use to make decisions. This unavailability of analytical information generated at the local level suggests that the lack of evaluation is having a negative impact on the development of evidence-informed policy and decision-making. It is Stame's (2004) opinion that this resulted into what she terms as an 'evaluation deficit'. Hills (2004) in her review of the evaluation of community level approaches for health improvement, also noted this 'evaluation deficit' as being a problem. In her review, she found that few systematic studies were done to examine the impact of the programme. A similar conclusion was reached by Bamba et al (2006:p.3), in their review of the evidence base, in which they found that there were "few evaluations of wider public health interventions". The lack of evidence from robust evaluation was also highlighted in the National Institute for Health and Care Excellence (NICE) public health guidance; Behaviour change, the principles for effective interventions (NICE 2007).

It is recognised by those who have reviewed the public health evidence base that evaluating complex health programmes is challenging and public health programmes delivered in primary care are becoming more complex and broad (Millward et al. 2003). There has been considerable debate about the approach that should be taken address the "evaluation deficit" and the generation of information that can be used to develop the public health evidence base (Stame 2004).

In 2008 the House of Commons Select Committee examined the evidence to understand the failure to reduce health inequalities and noted that

“despite a ten-year push to tackle health inequalities and significant Government effort and investment, we still have very little evidence about what interventions actually work. This is in large part due to inadequate evaluation of the policies adopted to address the problem” (House of Commons 2009: p28).

The focus of the criticisms has been on the inability to demonstrate that programmes implemented have had any effect on health outcomes, despite the availability of evaluation frameworks, evaluation text and the development of a specialist public health workforce (House of Commons 2009).

Public health academics, researchers and practitioners acknowledged that there was little available evidence to show the impact of programmes. Those presenting evidence to the committee explained that one of the key reasons for this lack of available evidence was that many of the key public health programmes delivered by primary care trusts during that period were never actually evaluated (House of Commons 2009). Professor Judge explained “what got passed off as evaluation and evidence were in fact no more than simple descriptions of the process” (House of Commons 2009: p 30).

Macintyre added to the debate, arguing that despite the availability of evaluation frameworks, evaluation texts and the development of a specialist public health workforce (House of Commons 2009), robust approaches were not used to evaluate public health programmes. In her opinion, the lack of robust evaluation was one of the main reasons why it was not possible to demonstrate the impact of the policies or have available evidence to contribute to improving services.

By 2009, when the Health Committee’s Health Inequalities report was published, it was apparent from the literature that there was little empirical information that could be used to inform and contribute to policy, aid decision making and develop a public health evidence and knowledge base. The conclusion reached by Health Committee members was that at the end of ten years of investment in a public health agenda to reduce health inequalities, there was limited understanding of which public health interventions were effective or cost effective. In addition, the Health Committee’s report concluded that programmes implemented to address health inequalities were not robustly evaluated by professionals within primary care, and that crucially, what was being done was not adequate to inform policy or to contribute to the public health evidence base (House of Commons 2009). This lack of available information on the effectiveness of programmes and interventions has therefore had implications, both for the promotion of evidence-based public health decision-making and for public health practice.

There was an acknowledgement of the need for a concentrated effort to ensure that future policies and programmes are robustly evaluated (House of Commons 2009).

“The Government is to introduce vascular checks; we urge it to do so with great care, and according to the steps outlined in chapter three, so that it does not waste another crucial opportunity to rigorously evaluate the effectiveness and cost effectiveness of this screening programme” (House of Commons 2009: p7)

It was acknowledged in the report and by leading researchers that there is a need for the adoption and use of agreed evaluation approaches and frameworks to provide the necessary information (Brownson et al. 2009).

However, what was missing in these debates and reviews was an understanding of why there was a lack of robust evaluation at the local level. Some reasons were proposed in the literature, but these primarily focused on the poor use of experimental approaches and poor programme implementation. For example, Kelly et al (2007) commented in their review that there is a lack of understanding of what was happening at practitioner level (Kelly et al 2007). In their review of the evidence base for social determinants of health, Kelly et al (2007) found that there was a lack of empirical data on understanding of how evaluation is achieved. Hills (2004) concluded in her review that there needs to be better understanding of how evaluation is viewed by those involved in delivering programmes, observing that very few systematic studies have been done to explore this.

It became apparent that in order to understand what should be done to promote more systematic and robust evaluation, a more comprehensive understanding of how the staff involved in implementing programmes perceive and conduct evaluation was needed. This research therefore aims to provide empirical data which presents an understanding of evaluation from the perspective of staff involved in implementing public health programmes.

### **1.3 Structure of the thesis**

This thesis is organised into three sections: section one, has three chapters, which include an introduction to the research, outline of the thesis, a review of literature and the research strategy. Section two, is the results section and contains the four findings chapters and section three is the discussion.

Chapter two, discusses the review of the literature that provided the background understanding to the research topic and contributed to the development of the research questions. In the absence of any substantive literature or research that explored how public health professionals perceived evaluation, a narrative literature review was carried out. This was to gain an understanding of how evaluation has been explored through theories in the field of evaluation. The debates and opinions of key evaluation theorists, Michael Scriven (1928), Carol

Weiss (1927), Michael Quinn Patton (1938) and Avedis Donabedian (1919) will be discussed. A critical discussion of the development of evaluation within the discipline of public health and the suitability of proposed evaluation approaches to provide the necessary information required to contribute to policy and service development and improvement then follows.

In Chapter three, the research strategy and research methods will be presented, including the methodological decisions that were taken by the researcher to shape the study design and approaches adopted to answer the research question. The chapter starts by discussing the reasons for adopting an interpretive, qualitative methodology and the rationale for using the National Health Service (NHS) Health Check programme to explore evaluation from the perspective of health professionals. An explanation for why the principles and techniques of ethnography and grounded theory were chosen to collect and analyse the data will also be discussed.

Section two, includes the four results chapters (Four to Seven) in which an understanding of the environment in which the participant were working is described and the emergent themes from the analysis of the data are presented. Chapter four presents the finding of the documentary analysis of the review of the national and local policy documents and guidance documents available to participants was undertake, in order to get an understanding of how evaluation was represented in these documents. In this chapter the contents of the documents were explored to understand how evaluation was represented in the material that professionals used to implement and evaluate the Health check programme. This analysis of the documents illustrated that the representation of evaluation varied according to the origins of the policy and guidance documents.

Chapter five, is primarily descriptive, and aims to provide an overview of the environment in which the participants were working. The structures and arrangements that were in place to support the implementation of the health check programme are described as well as a description of participants' roles, responsibilities and positions within the organisation.

In Chapter Six, the participants' perceptions of evaluation are presented. This analysis revealed that definitions of evaluation were, in part, based upon the participants' training and background, and the context in which evaluation was being discussed. It was found that context in which evaluation was discussed heavily influenced participants' views about what evaluation was and what it was meant to achieve. A key distinction was made between formal and informal evaluation, with the former being associated with a more theoretical and abstract concept,

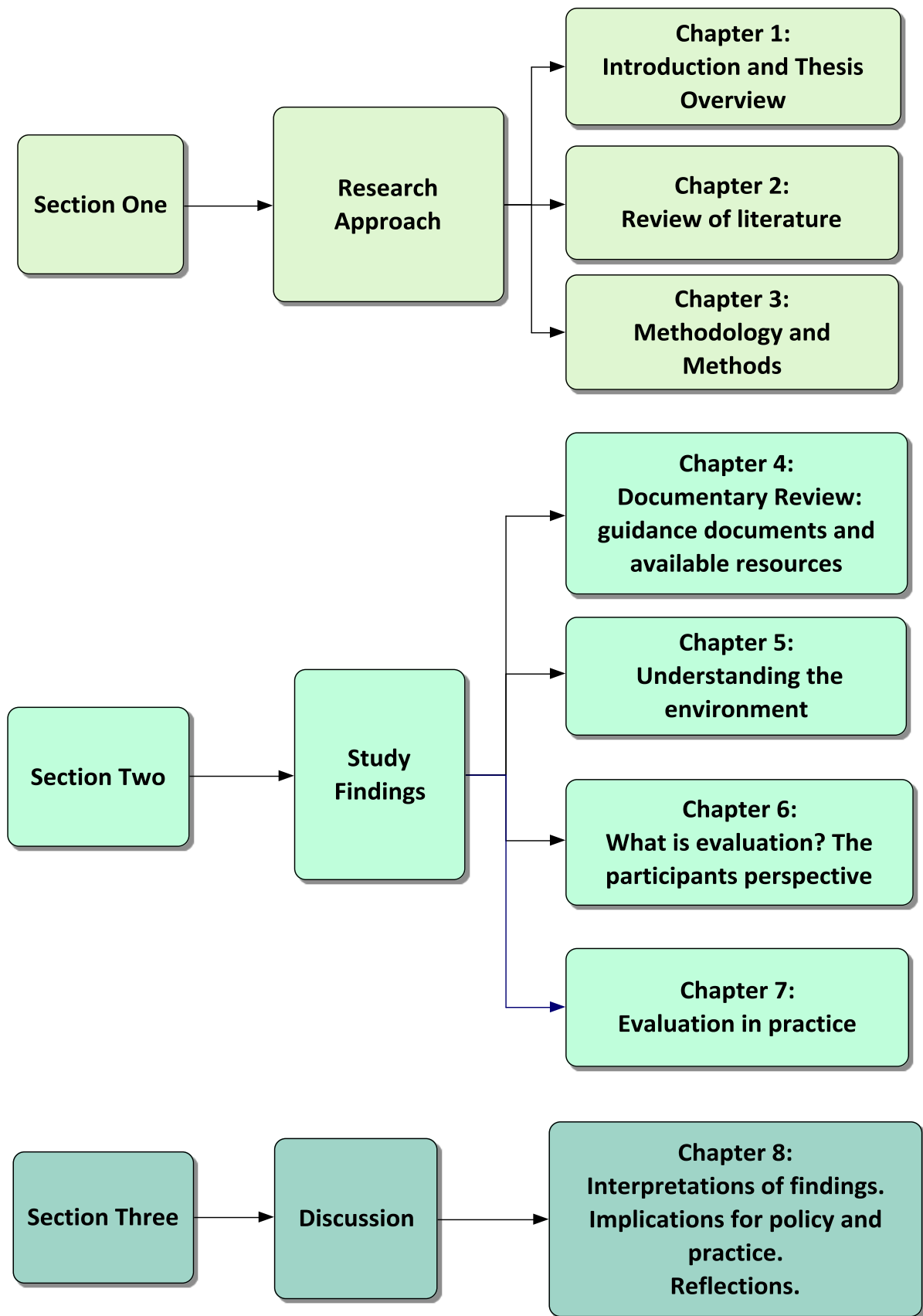


whereas the latter was associated with the more practical undertaking of evaluation, and a much more instrumentalist approach.

In Chapter Seven, the findings from analysis of the interviews and observational data are presented that are used to provide an explanation of what happens in practice and how participants manage their organisational and individual duties and obligations to evaluate.

The final section is the discussion chapter, which presents the findings which emerged through the analysis. The findings are discussed in the context of the theoretical and existing literature that was used to help to gain a deeper understanding of evaluation in practice from the perspective of public health professionals. The implications of findings of this study for public health policy and practice will then be discussed in the context of current policies and the working environment of the participants. The chapter will conclude with a discussion of the study's main strengths and weaknesses and reflective account that includes the researcher's perspective of the study process and procedure, finishing with a conclusion.

**Figure 1: Thesis Structure**



## Chapter Two:

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### 2 Review of the literature

#### 2.1 Introduction

The initial question proposed at the start of the research process was "how is evaluation perceived and carried out by public health and health professionals?" This broad question guided the search of the literature to get the necessary background information and to establish what other empirical studies had been done on this topic. This chapter will provide a review of the relevant literature that contributes to an understanding of evaluation in the context of public health practice. A set of research questions will be articulated at the end of the chapter.

The purpose of conducting a review of the literature was to obtain a broad and rich background understanding of the research topic. This was done by reviewing the literature on the development of the discipline of evaluation and of evaluation within public health practice in the UK. First, a brief outline of the methods used to carry out this review will be presented. This will be followed by an exploration of development of evaluation through an examination of the debates and opinions of the following theorists and academics; Michael Scriven (1928), Carol Weiss (1927), Michael Patton (1938) and Avedis Donabedian (1919). The nature of their contribution to evaluation practice and its relevance to public health evaluation is examined, followed by a discussion that explores some of the key debates on the state of evaluation within public health. The implications of the changes in health policy on evaluation within public health and the suitability of proposed evaluation approaches to provide the necessary information will be discussed. Lastly, the impact of the lack of robust evaluation of public health programmes on the development of evidence-informed public health practice will be a discussion.

#### 2.2 Methods

A scoping review was done to establish the breath of studies published that explored evaluation from the perspective of professionals. The following research terms were chosen: evaluat\*, perceptions, primary care, public health, health profession\*, evidence, effectiveness,

barriers, facilitators. The electronic databases; Google Scholar, Medline, Biosis, Ovid, Pubmed, ERIC and ASSIA were searched. After a number of searches using different combinations of the search terms, the articles found were not considered relevant, as they either explored staff perceptions of the utilisation of evaluation, or the use of research evidence to improve services or change practice.

To increase the sensitivity of the search to locate studies that were relevant to the research question, techniques such as citation searching, bibliographic searches, hand searching and snowballing were used to identify relevant studies. A health service librarian also conducted a search to confirm that relevant studies could not be located. Subsequently, one study was found that met most of the search terms and criteria. This study, carried out by Taut and Alkin (2003), explored educational professionals' perceptions of the barriers to the implementation of external programme evaluation. The study and its findings will be discussed in more detail in section Understanding evaluation in practice from the perspective of professionals' section 2.6 in this chapter.

As a significant body of research which focused on exploring evaluation from the perspective of health professionals was not found, a narrative literature review was carried out. The purpose of the review was to provide background literature, identify gaps in the body of knowledge and use this information to refine the research question. A narrative literature review allows a wide body of material on a topic to be examined, and the nature and scope of the literature in the area of interest to be explored in more depth (Hart 1998). With a narrative review, iterative and inductive approaches are used to explore the literature and it is therefore not essential to set rigorous selection and inclusion criteria (Hart 1998). The nature of the research topic and the lack of relevant research literature meant that the opinions of key authors and researchers in the field of evaluation and public health were used to guide the selection of articles.

The following terms were used to initiate the search for the material in the review: public health, perspective, professionals, barriers, facilitators, evidence and health. Where the terms were combined with "evaluation" in the title or abstract, the articles were retrieved for scrutiny. Firstly, a broad scan of the literature was undertaken to determine the extent of the theoretical literature available to build an understanding of the issues and debates surrounding evaluation in general and evaluation in public health practice specifically.

The articles selected were largely written by leading evaluation and public health academics. These articles provided the historical context of evaluation, as well as an outline of

the theoretical, methodological and practical aspects of evaluation and evaluation within public health. In addition, UK government health policy documents and national and international reports were reviewed.

The current issues associated with the evaluation of public health programme in the UK were explored in this literature. The current and past editions of the leading peer reviewed journals on evaluation, including *Evaluation*, *Evaluation Practice*, *American Journal of Evaluation*, *Journal of Public Health* were hand searched to identify debates and opinion articles from key authors and relevant papers based on evaluation theory and evaluation research.

A search of the literature was also undertaken at the end of the research period to check for new literature that might be relevant to the research topic. No new literature was identified other than a body of literature in which the focus was the utilisation of evaluation evidence in practice, which was not the focus of the research.

The following sections in the remainder of this chapter discuss the topics and issues that emerged from the articles and policy documents.

### **2.3 An overview of evaluation: historical and theoretical perspectives**

The aim of this element of the review of the literature was to get a better understanding of what evaluation is, in terms of its historical origins, and its theoretical and methodological foundations. It also aimed to analyse leading opinions regarding the purpose of evaluation and what it aims to achieve. At one level, evaluation forms part of everyday living and is considered to be a necessary aspect of human existence. However, Scriven (1994) noted that there is a difference between evaluation as an everyday activity, and evaluation as part of professional practice.

‘evaluation as an essential ingredient in every practical activity-where it is used to distinguish between the best or better things to make, get, or do, and less good alternatives’ (Scriven 1994: p 152)

Simply put, evaluation is about making decisions related to choosing between different options. It is the formalisation of these everyday activities into agreed structures, processes and procedures, over decades, that has evolved into the field of evaluation (Scriven 1994). The field of

evaluation now comprises of a range of disciplines, perspectives, approaches and models (House 1980, Patton 1998, Scriven 1994, Stufflebeam 1999).

This formalisation of evaluation as a discipline began in the 1950s, in response to the implementation of the Great Society and War on Poverty programmes in the United States (Patton 1998). The implementation of a large number of social programmes gave those in the applied social research community the opportunity to do field experiments and try out different approaches to evaluation (Rossi and Wright 1984). Before this, evaluation studies were conducted by professionals from different disciplines, and the quality of approaches and findings varied (Stufflebeam 1999). According to Scriven this has led to the development of evaluation as a general discipline with a range of applied areas. These include what he has categorised as “the big six” - programme evaluation, personnel, performance, product, proposal and policy. These are evaluations developed within a discipline such as physics, and conducted by professionals who have a good understanding of their discipline, very rarely using trained evaluators, these he defines as discipline specific evaluations. This type of evaluation is only relevant to a specific discipline and is done to meet the particular functions (Scriven 1994).

The uncoordinated use of various methods and processes being branded as evaluation was deemed unacceptable to evaluators and social researchers engaged in evaluating programmes (Stufflebeam 1968). A group of academics from the educational and social sciences disciplines decided that there was a need to have a theoretical framework to connect the different fields that were developing with very little interaction among them (Stake 1973). There was also a recognition that evaluation, as a discipline, will always be made up from a diverse set of models and approaches. Therefore striving to create some core principles was going to be challenge. What emerged from this period formed the foundations for future developments in the field of programme evaluation.

Programme evaluation according to Stufflebeam (2001) is any 'coordinated set of activities directed at achieving goals'. It has now become a recognised term used to signify the evaluation of any complex programme, in any discipline, aimed at improving the lives of people (Weiss 1972). The term programme evaluation has a history of being used within the public health community, with the first reference to it made by Sheps (1955). Sheps used this term to describe the structures and methods she thought needed to be in place in order to assess both the quality of medical care and the impact of health interventions on the population.

While the discipline of assessing the impact of social and educational policies was developing, evaluation within public health was also evolving, taking a number of different

routes. The principles and methodologies that underpinned evaluation within public health practice originated from the fields of medical research, epidemiology and economics. The methods and approaches used drew largely on epidemiological and scientific principles. The primary focus of public health policy, at the time, was on reducing the burden of communicable diseases, and on understanding the impact of health care services and medical intervention (Donabedian 1970). Therefore, the approaches developed were ones which enabled the effectiveness and efficacy of medical treatments, health technology and health services to be appraised and measured (Detels et al. 2002). Even today, public health evaluation practice is still based on Donabedian's (1966) framework that is primarily used to assess the quality and impact of health care services in terms of structure, process and outcome.

### **2.3.1 Evaluation as a form of research**

Evaluation has often been described as a form of applied research in which a combination of scientific methods was used to collect and analyse information to assess a programme. At the centre of the debates regarding the nature of appropriate methodology in evaluation practice are concerns about the epistemological position that the practitioner should take when undertaking an evaluation. At the core of this debate is the issue of whether evaluation should be considered a science or a service activity.

Scriven (1998) points out that the use of systematic approaches and methods to collect and analyse data does not qualify a process to be a scientific one. He suggests the core principles underpinning the methods and processes used in evaluation are similar to those used in scientific research. This point has contributed to this continual debate regarding the discipline of evaluation. Scriven (1998) goes on to argue that evaluation is not a value-free strategy, therefore it would be difficult for it to meet the criteria of what he terms the "value free dogma" that exists within the scientific world. He sees evaluation as having the potential to become a discipline with its own epistemological position that is separate from those underpinning scientific inquiry.

It is this concept of value that Davidson (2005) feels differentiates evaluation from research, as evaluation is primarily concerned with the 'so what'. Smith (2010) has a slightly different view and sees evaluation as a science, of which there are a number of research fields, each having its own particular perspective. Patton (1998) takes a broader view suggesting that evaluation can exist as both a scientific research activity and as an applied research activity. He

suggests that the use of a systematic approach to assess a programme is important and that it needs to be acknowledged that evaluation will be approached differently by academic evaluators and service evaluators, particularly as they will have different goals to achieve. Weiss (1972) agrees with this view, as she too considers evaluation is a specific method of research in which research tools are used to make the process more accurate. Stoto (2008), like Weiss, views evaluation as an applied research activity used to assess state:

“evaluation is essentially an applied research activity seeking to discover whether a program, in some sense, has beneficial effects for the public’s health. The whether a program, in some sense, has beneficial effects for the public health” (p.498).

There is also some debate around the legitimacy of evaluation being considered a form of scientific research. Scriven (1998) feels that there is very little justification to reject the notion that evaluation is a form of scientific research and that the arguments surrounding these debates are mainly academic and philosophical. Scriven (1998) classifies evaluation as a ‘tool discipline’, as it draws on different techniques that are supported by the same principles and procedures that would be employed in scientific studies (Scriven 1998). The ensuing debates about evaluation being a form of scientific inquiry are strongly connected with processes and procedures used to collect data and its interpretation, the credibility of the results, and the quality of the information that certain approaches could provide. Central to these debates is the issue of the credibility of results from evaluations conducted internally. For example, the main concern raised by House (1986) was the difficulty in preventing results being biased or subjective.

### **2.3.2 The purpose of evaluation**

The other argument in this debate is focused on the purpose of evaluation. The public debates between Scriven (1994), Patton (1998) and Weiss (1993) highlighted the difference in conceptualisation of evaluation as a process and in particular, the purpose of evaluation and what it should aim to achieve. Patton (1998) strongly objected to Scriven's rigid position that the only purpose of evaluation was to provide information to assess if something is working or not and if assessed as not working, to stop doing it (Scriven 1998). Weiss (1972) does not agree with this stance as she views the aim of evaluation should also be to provide information to improve a programme whether or not it was found to be effective.



“The purpose of evaluation research is to measure the effects of a programme against the goals it sets out to accomplish as a means of contributing to the subsequent decision making about the program and improving future programme making” (p.4)

Both Patton (1998) and Weiss (1998) proposed that evaluation should be about (programme) improvement and not be restricted to measurement and judging the quality. Evaluation in their view should be used for a number of reasons: to identify areas in which improvements need to be made, as well as to make an assessment of the quality or value of a programme. What emerged from these public disagreements were different views on the purpose of what evaluation should be and what it should achieve as a process.

In contrast, Donabedian (1976) viewed evaluation as serving a very different purpose. For him, it was a means by which to assess the quality of health care. The purpose for evaluation was to ensure that services being delivered improved health outcomes. This was to be done through systematic examinations of the relationships between the quality of care and resource expenditure (Donabedian et al. 1982).

These debates about the purpose of evaluation have in many ways, paved the way for similar debates within public health practice. In particular the debates about the introduction of evaluation approaches, which move away from the epidemiological and experimental models that have been traditionally used within the discipline of public health. At the core of these debates are issues around the origins of the underlying theoretical and methodological principles of evaluation and what was deemed as acceptable within research and academic communities.

Theory based evaluations are informed by different approaches and frameworks (Blamey and Mackenzie 2007). The two most commonly used in the UK are theory of change and realistic evaluation (Blamey and Mackenzie 2007).

Pawson and Tilley (1997) developed the realistic evaluation' model to understand the impact of contextual conditions and to use this understanding to develop lessons about how to produce outcomes to inform policy decisions. It involves taking into account the varying conditions in which an interventions takes place and gaining an understanding of the significance of these conditions.

A key aspect of the realistic evaluation model according to Pawson and Tilley is the generation of 'context mechanism, outcome pattern configurations (CMOC) and it is this that enables an understanding of outcomes and the factors that influences them and how they can be used to addressed a particular set of circumstances (Pawson and Tilley 2004).

The strength of the realistic evaluation approach is that it enables an understanding of the effects being produced by the intervention which then allows the evaluator to gain insights about 'what works for whom in what circumstances' (Pawson and Tilley 2004).

It is this aspect of realistic evaluation that make it an attractive evaluation model for public health as it provides a framework to take into account the effects of the circumstances surrounding the implementation of a programme.

In essence, evaluation is a process that is used to generate relevant information to make a judgement of the value of a programme or an intervention, importantly to decide if it is worth funding, disinvesting in or implementing on a wider scale (Smith 2001). In 2013 in an evaluation workshop at the Australian society conference in Brisbane Scriven outlined that the main purpose of evaluation is to show whether a programme is working or not.

There are clearly many different theoretical and methodological contributions to the development of the field of evaluation, and a number of different schools of thought, disciplines, models and approaches have been formed. However, there is general agreement that systematic procedures and approaches are necessary for robust evaluation. The appropriate nature of these approaches has been the topic of another set of debates and disagreements amongst leading evaluators and academics about whether evaluation should be considered a form of research or not (Weiss 1993, Scriven 1994, Patton 1998).

### **2.3.3 External versus internal evaluation**

In another key development of the discipline of evaluation, Scriven (1996) observed untrained evaluators, who had a good understanding of their discipline tended to carry out evaluations. Scriven was not in favour of this development because, in his view, evaluations should only be carried out by trained evaluators who were external to programmes (Scriven 1996). Scriven's rationale for this view was that a trained evaluator would be more objective because they would be less likely to be directly involved in programme delivery.

This view highlights important methodological issues about who is in the best position to carry out a useful evaluation. These arguments relate to the skills and qualifications required by those carrying out evaluations. This has led to number of debates about the advantages of internal and external evaluation, which Weiss (1972) describes as "in-house" and "outside"

evaluations. At the core of this debate is the question of who can provide the findings that are most credible.

On this subject, there was a divide amongst the evaluation theorists. On one hand, Scriven (1996) held strong views that trained evaluators who have no connection to the programme provide the most credible results and should be the only people evaluating programmes. Others like Weiss (1972) and Patton (1998) are more circumspect, arguing that those involved in delivering a programme have a better understanding of the context, and can therefore make valuable contributions to the findings and are more likely to ensure that the results have meaning.

The strongest views regarding the merits of internal evaluations have come from House (1986). It is House's view that there are inherent problems with evaluations being done by those who are also involved in implementing a programme. House (1986) argues that the main concern when programme staff evaluate the programmes they are implementing, the findings of these evaluations can be compromised. House (1986) considers this problematic because it is more likely that the evaluation process can become distorted, as evaluators may become influenced by what the administrators of the programme require. House (1986) argues that because of this evaluations conducted internally have a tendency to be biased and the findings cannot be considered as being robust because they are influenced by these administrative factors.

Sonnichsen (1987) disagreed with House's views, arguing that evaluation done internally can provide context and with the right procedures in place, having someone who understands the contextual aspect of a programme is beneficial to the process. The resultant findings and recommendations are more likely to be accepted. Lyon's (1989) agrees to some degree with House about the inherent problems with internal evaluation but thinks that a mixture of in-house and outside evaluation can be beneficial if it is managed well. The most important contribution regarding who is best placed to evaluate a programme has been provided by Weiss (1972). Weiss (1972) suggests that it does not really matter if an evaluation is done in-house or outside, what matters are how the following factors are met: administrative confidence, objectivity, understanding of the programme, potential for utilisation and autonomy.

The theoretical debates and disagreements may have obscured the practical application of evaluation by introducing a myriad of philosophical viewpoints, approaches, models and practices. Evaluators involved in evaluating public health programmes draw on a wide range of potential approaches that have become detached from their philosophical roots. The next section will explore in more detail the development of evaluation within public health and

explore the implications of the changing nature of health policy and health service reform on evaluation practice in the UK health system.

## **2.4 Public health and evaluation: a UK perspective**

The remit of public health is changing and countries across the world now have a significant proportion of their populations living with one or more of the following communicable diseases: cardiovascular disease, diabetes, cancer and respiratory disease, each causing significant burdens to populations and economies (World Health Organisation 2008). World Health Organisation (WHO) Global Health Plan 2008-013 estimates that 80% of cardiovascular disease (CVD) and a third of cancers are preventable. Non-communicable diseases, smoking, obesity, physical inactivity and alcohol misuse share risk factors with these communicable diseases. These risk factors are linked to behaviour, lifestyle and material deprivation (World Health Organisation 2008). Disease prevention and control programmes therefore need to enable individuals to modify their behaviour and adopt healthier lifestyles.

It is now accepted that health care systems and medical treatment only play a small role in the control of communicable disease, and approaches that address the wider determinants of health are now required (World Health Organisation 2008). WHO's Global Health plan 2008-013 advocates the implementation of integrated health programmes which include both primary and secondary prevention approaches and contain activities that address both prevention and control.

In the United Kingdom, public health was presented with two key functions - to develop interventions that reduce inequalities in health and to address the social determinants of health (Orme et al. 2003). The Acheson Report raised concerns about the damaging impact of inequalities of health, paving the direction of future public health policies and health system reform in the UK (Acheson 1998). 'Saving Lives: Our Healthy Nation' (Department of Health 1999) and the Public Health White Paper 'Choosing Health' (Department of Health 2004) built on Acheson's recommendations and put addressing the social aspects of health firmly on the UK's health policy agenda.

One of the core messages of 'Saving Lives' was lifestyle change through enabling, empowering and engaging the community, and creating supportive environments. International

papers, such as 'The Solid Facts' (Wilkinson and Marmot 2003), echoed this message, calling for policy makers and governments to recognise the influence of social and economic circumstances on health. Alongside this drive to arrest the growing burden of non-communicable disease in the UK has been a restructuring and refocusing of the health policy and public health efforts. The NHS was to become an organisation that provides good quality of care and services with public health having a key role in generating that would be used to support the commissioning of effective interventions (Department of Health 2004).

In response to these changes, organisations such as National Institute for Clinical and Excellence (NICE) were launched. At the same time the National Service Frameworks (NSF) and guidance documents were developed to support the delivery and evaluation of the programmes and interventions that were being put in place to improve health and reduce health inequalities (Department of Health 2000, Department of Health 2004). Funding was allocated for the development and training of a specialist public health workforce who could provide the leadership and coordinate the implementation and evaluation of the programmes (Orme et al. 2003).

Public health professionals were now expected to play a bigger role in creating evidence for an evidence-based public health service (Reeve and Peerbhoy 2007). In this change of focus of public health activities, the role of public health professionals regarding evaluation was succinctly put by authors of the Framework for Programme Evaluation in Public Health (Centre for Disease Control 1999).

Health improvement is what public health professionals strive to achieve. To reach this goal we must devote our skill and will to evaluating the effects of public health actions (Centre Disease Control 1999: p.4)

In the UK, public health departments would have a role in ensuring successful delivery of programmes. Public health professionals were going to evaluate programmes and interventions to produce the information required to contribute to the evidence base and to inform policy (Department of Health 2004). This new specialist workforce was to include public health specialists, public health practitioners and the wider workforce, including the voluntary sector (Orme et al. 2003). Every primary care trust was to have a Public Health Directorate that would provide leadership and coordinate the delivery of programmes (Department of Health 2000). The national standards for public health specialists gave credence to public health's political and social responsibilities (Chapman et al. 2005). These new functions, roles and responsibilities illustrate the clearly defined roles of public health professionals.

### Box 1: Definition of Public health specialists

Chapman (2005: 640)

Consultants in public health medicine and specialists in public health working in the National Health Service may come from a variety of backgrounds such as public health sciences, including communicable disease control, environmental health and other aspects of health protection, social science, medicine, nursing health promotion and dentistry. They have a common core of knowledge, skills and experience and operate at a strategic or senior management level. This definition includes not only those with a medical background who are on the General Medical Council specialist register, but also others practising within public health teams at a comparable level of responsibility.

These new functions were reflected in Orme et al's (2003) Skills for Health report, summarising the roles of public health practitioners as follows:

- Improve health and well-being in the population
- Prevent disease and minimise its consequences
- Prolong valued life
- Reduce inequalities in health

The aim of these new arrangements and functions were to ensure that there was capacity and capability in the system to produce the necessary information to contribute to the evidence base (Orme et al 2003). The wide scope and increased social function of public health was further reflected in the 'Skills for Health' report (Department of Health, 2002) which had developed the areas of competence for public health specialists.

### Box 2: Competence for Public health specialists

Skillsfor Health(2002)

1. Surveillance and assessment of the population's health and well-being (including managing analysing and interpreting information knowledge and statistics)
2. Promoting and protecting the population's health and well-being
3. Developing quality and risk management within an evaluative culture
4. Collaborative working for health and well-being
5. Developing health programmes and services and reducing inequalities
6. Policy and strategy development and implementation
7. Working with and for communities
8. Strategic leadership for health
9. Research and development
10. Ethically managing self people and resources (including education and continuing professional development)

### **2.4.1 Evidence-based public health policies and practice and evaluation practice**

Fundamental to this agenda was that both the effect and cost effectiveness of public health programmes needed to be demonstrated, as this is the information which is essential for the development of the public health evidence base (Reeve and Peerbhoy 2007). An evidence-based approach was to be adopted to ensure that appropriate services and interventions were identified and used (Law 2009). The NHS Plan released in 2000 emphasised the importance of an evidence-based approach to decision-making and policy development. In particular, there was a drive for the NHS as an organisation to become more accountable and to demonstrate that the services they were providing were effective both in cost and in improving the quality of care (Law 2009). Public health professionals were expected to be evaluating programmes to contribute to the evidence base so that health policy, interventions and decision-making was based on the best available evidence (Reeve and Peerbhoy 2007). In situations where there was little or no evidence, this was to be generated through evaluation and research.

Despite the longstanding nature of an evidence-based public health movement, a number of recent reviews have all commented on the continuing lack of available evidence to demonstrate the impact of lifestyle interventions and the need for more robust evaluation of public health programmes (Wanless et al. 2004, Petticrew et al. 2004, Bambra et al. 2006). It has been argued that the evidence base needs to be increased and robust evaluation needs to be carried out and reported (House of Commons 2009). Furthermore, recommendations in a recent NICE report (2010) have called for more research that will contribute to the evidence base on the effectiveness of public health interventions.

Evidence-based public health practice also added another dimension to evaluation. As there has been a growing demand for the use of evaluation approaches that can provide evidence to demonstrate an effect in terms of changes in health outcomes as well as cost-effectiveness of programmes or interventions.

### **2.4.2 The evaluation approaches within the discipline of public health**

The multidisciplinary nature of public health practice adds its own dimension to evaluation practice. Public health delivers programmes that address both the medical and social

needs of populations and draws on a number of methods and approaches from various disciplines. Therefore, a distinctive field of public health evaluation has been created. Evaluation in public health can be separated into the types of evaluation associated with clinical interventions and medical care, and types of evaluation associated with health programmes that are social in nature.

Evaluation approaches specific to the discipline of public health have evolved to address the specific needs of the different spheres of public health practice. Smith (2010) points out that originally public health evaluation focused on effectiveness and efficacy of medical treatments, technology and services. The focus was on single interventions, and pharmaceutical or treatment orientated, measuring the impact of the intervention or treatment on individuals. Evaluation traditionally was underpinned by scientific research principles and design, and these have been the dominant approach within the NHS (Smith 2010). Evaluation was strongly associated with research approaches, with Randomised Controlled Trials (RCT) considered the gold standard in research design. Findings from evaluations conducted using this research design were considered the most robust (Reeve and Peerbhoy 2007).

However, the remit of public health evaluation according to the Handbook of Public Health (Pencheon et al. 2008) is now much wider. The focus of public health evaluation was on the assessment the quality of health care services, monitoring the impact of services on health status and measuring changes in health status. Smith (2010) goes further pointing out that the most common approach to evaluation within a NHS setting is in fact service evaluation, which focuses on gathering and analysing data to assess the structure, process and outcome of a programme or service.

These developments in the discipline of public health evaluation are evident in the UK, and are largely in line with the development of health policies and approaches aimed at reducing the impact of communicable diseases and the appraisal of the impact of the delivery of health care on population health. As Detels et al (2004) note, evaluation follows the 'backbone of public health strategies'. However, despite these changes, it can be argued that public health approach to evaluation has not fully adapted to address a mixture of biological, cultural, social and environmental factors.

In addition to changes in the focus of public health function, there has been a broader movement toward evidence-based health decision-making around both investing and dis-investing in health care services and interventions (Davis 2000). The changing focus of public health priorities of the last century has meant that public health has had to adopt new



approaches to evaluation, in order to meet the needs of policy makers. At the same time, the scope of public health has been widened with public health functions now covering a wide remit of activities. These now include involvement in delivering and assessing health care system reform, commissioning health services, monitoring and surveillance of the population's health, developing and implementing screening and immunisations programmes. The authors of the Framework for Programme Evaluation in Public Health (Centre Disease Control 1999) recognised that evaluation is becoming more complex, as public health activities have expanded to include the control and prevention of chronic diseases, addressing the social determinants that influence disparities in health, violence, emerging diseases and bioterrorism

Stoto's (2008) list of the different evaluation approaches and models now used within public health is an illustration of the diverse range of activities carried out by public health, and also demonstrates the many different approaches public health practitioners can choose from:

- "Traditional evaluation"- this type of evaluation is used to assess the impact of a programme activity on pre-defined outcomes.
- "Economic evaluation"- approaches within economic evaluations are used to determine the effectiveness of a programme in terms of its cost and the allocation of financial resources.
- "Process evaluation"- the goal of these types of evaluations is to determine the relationship between output and outcomes.
- "Formative evaluation"- uses approaches to identify the best available resources before a full programme evaluation is carried. These tend to use qualitative methods, such as focus groups.
- "Empowerment evaluation"- this approach is used to enable stakeholder involvement and the focus is on the objective of programme improvement.
- "Performance measures"- this is an on-going process in which statistical measures and other evaluation methods are used to ensure accountability and improve programme performance.

The Centre for Disease Control's (CDC) programme evaluation framework is a framework that has been developed to assess complex public health programmes and according to its developer, can be adapted and used for the full range of public health programmes (Centre for disease control 1999). The term “programme”, in the framework was described as 'the object of evaluation which can be any organised public health activity' (Centre for Disease Control 1999). The core elements of the framework are based on principles and methodologies of programme evaluation that have originated from Scriven (1994), Weiss (1972) and Patton (2001). It also draws on the principles of epidemiology and medical research. It is an illustration of how different evaluation paradigms have been drawn together to produce an integrated approach to evaluating programmes within public health.

There has been little evidence that public health practice has adopted these alternative approaches to evaluation in the UK until recently. There is now a drive by Kelly et al (2007) to use theory driven approaches to evaluate public health programme and initiatives. The NHS guidance for the commissioning of primary care services to improve health outcome, recent NICE public health guidance (NICE 2007, 2010) and DH guidance on the implementation of the Health Check programme (Department of Health 2009) advocate the use of programme evaluation approaches.

McIntyre, on the other hand, strongly recommends that the basic evaluation principles listed below should be used. Professor Macintyre (House of Commons 2009) argued for the use of more scientific, robust approaches to evaluate programmes, and set out the following considerations that should be taken into account to illustrate her point.

### Box 3: Principles for policy design and evaluation

- \* importance of a counterfactual-usually provided by a control group (i.e. what is likely to have happened without the intervention);
- \* choose a design according to the specific features of the evaluation (e.g. likely size of effect, proportion of the population affected, and risk of bias) rather than general assumptions or traditions in a particular field;
- \* consider the whole range of possible experimental designs; cluster randomised, stepped wedge, comprehensive cohort, interrupted time series etc;
- \* always consider randomisation as the most robust method of preventing bias, as it works against unknown and unmeasured confounders as well as known/measured ones
- \* the need for prospective methods-with a baseline to be established and data collected before the intervention is rolled out;
- \* the need for the primary outcomes to be established and agreed a priori (to prevent post- hoc selection of those that look good when the participants do worse on the main outcomes);
- \* appropriate lengths of follow-up, relative to the outcomes of interest; \* objective assessment of both positive and negative outcomes;
- \* building in methods of measuring long-term and potentially adverse consequences, such as obtaining consent to follow-up, gathering supplementary information to enable tracking, flagging participants in health service registries;
- \* non-suppression of unhelpful negative findings;
- \* importance of measuring direct and indirect impacts-not just the obvious direct impacts (e.g. urban renewal may improve the infrastructure in a target area, but local residents may not be able to afford to live there any longer and may have to move out);
- \* explicit statements/the theories/evidence about how the intervention is expected to work;
- \* collect information about how the intervention is actually implemented (as opposed to how it was expected to work);
- \* in particular in relation to inequalities, collect about impact by gender, age, ethnicity and socio-economic status;
- \* include an economic evaluation.

(House of commons Health Committee 2009: p 36)

Beaglehole et al (2004) point out that a key element for success in this new era of public health evaluation would be the adoption of wider approaches to evaluation. This would depend on the approaches public health as a discipline chooses to adopt to gather, interpret and analyse socially derived information. In reality, Beaglehole et al (2004) argue that the high regard for biomedical, scientifically derived information gained through epidemiological studies is not generally suitable for evaluating public health interventions that are currently being implemented.

## **2.5 Evaluation from the perspective of professionals.**

As has become apparent from the literature discussed above, the perspective of those implementing programmes has been lacking in the debates regarding evaluation. A search of the literature for empirical data which explored the perceptions of evaluation in a service setting produced one study which had explored evaluation from the professionals' perspective in an educational setting (Taut and Alkin 2003). This qualitative study explored what educational professionals perceived to be the barriers to evaluation implementation. They organised the identified barriers into three main categories - human factors, evaluation factors and contextual factors. The researchers were essentially exploring the professionals' 'personal insights' into these barriers. The aim of their study was not to gain an understanding of barrier to evaluation from the perspective of those involved in delivering a programme. Their study focused on examining programme staff perceptions of evaluations that were done by evaluators who had been external commissioned to evaluate the programme. However, this study did provide some insights into the way evaluation is perceived in practice. The findings confirmed what the authors had already established from a previous study on the barriers to evaluation utilisation. The barriers they identified were ones that were concerned with how programme staff worked with and were accepting of the recommendations proposed by external evaluators.

It was their view that this is an area of research that has not been sufficiently explored and that there is a need to gain a better understanding of how evaluation is perceived and carried out by programme staff in different contexts. They concluded that more empirical research in more diverse areas would add to the generality of their findings. This conclusion is additional evidence of the need for more empirical research in other professional fields and justifies a study that explores perceptions of evaluation with a different group of professionals.

## 2.6 Summary

Overall, the review of literature highlighted the diverse nature of the discipline of evaluation. There were many different views about how evaluation should be conducted and what its purpose should be. The concepts and methodologies that form current evaluation practice within public health practice have originated from a number of fields, including education, social sciences and medicine. The body of literature on evaluation was vast and diverse, and illustrated the rich nature of the field of evaluation. This review has focused on the contributions from authors Scriven (1994), Weiss (1972), Patton (1998) and Donabedian (Donabedian 1966) on the theoretical and procedural aspects of programme evaluation. Scriven, Weiss and Patton all made significant contributions to the development of the field of programme evaluation, and the development of some of the key concepts and approaches used to assess the impact of complex public health programmes. However, it is the criteria and framework proposed by Donabedian that has largely informed the basis of the approaches that have been used within public health practice in the UK to evaluate healthcare programmes. It is still currently the most commonly used framework used to evaluate public health programmes.

The changing focus of public health interventions towards disease prevention programmes with an emphasis on changing lifestyles means that public health programmes delivered by staff working in primary care have become more complex and multifactorial. Practice is increasingly aimed at addressing socio cultural and behaviour factors. This change in focus in public health activity has not been reflected in evaluation practice within public health, as the frameworks and principles that were originally developed to assess and appraise the impact and quality of healthcare services are the ones that are still commonly used (Donaldson 2003).

The quality of the evidence base to assess the impact of public health programmes is considered inadequate, despite policy reforms and funding for building evaluation capacity within public health (Kelly et al. 2004). The reluctance to discontinue using the traditional public health evaluation approaches has been identified as a potential barrier to adoption of approaches, better suited to evaluating programmes that are aimed at changing behaviour and lifestyle (Kelly et al. 2007).

It was evident from the review of the literature that the strong opinions amongst leading academics have failed to provide a consensus about what evaluation as a process should achieve. These debates have resulted in a vocabulary that is confusing. There is no agreed common

definition, but there was a plethora of approaches, models and frameworks available for use. What has also been established from the literature review is that there is currently limited knowledge of how public health professionals who implement programmes view evaluation or understand how evaluation is carried out in practice.

## **2.7 Study rationale**

The rationale for this study was primarily the researcher's experience of being a member of a public health directorate delivering a national programme at local level. Additionally, the Health Select Committee on health inequalities (2009) concluded that there was a lack of robust evaluation undertaken by public health staff working in primary care trusts. These factors led the researcher to want to gain a better understanding of how public health practitioners perceived and carried out evaluation, particularly as their voice was not represented in the key policy documents.

After reviewing the opinions and views of leading theorists and academics, it was apparent that the field of evaluation was both diverse and discipline specific. In addition, from the extensive debates in the literature, it was possible to identify many different methodological viewpoints that shape the different forms of evaluation. What appears to be missing in the current literature are the opinions of those actually involved in delivering and evaluating public health programmes.

A key feature of this overview of the literature was the absence of substantive empirical research carried out to understand the perceptions of evaluation of those working in a healthcare environment. Few empirical studies were identified in the literature that explored evaluation from the perspective of professionals working in the NHS's primary care service settings. There seemed to be very little knowledge and understanding of how public health professionals involved in implementing national programmes locally perceived and conducted evaluations in a primary care trust environment.

The lack of a body of empirical research was an indication that this was a topic that was under researched. Based on this review and understanding of the literature, the following three research questions emerged:

1. How is evaluation perceived by public health and health care professionals working in a primary care setting?
2. How do public health professionals and health care professionals evaluate national programmes that they are implementing locally?
3. What information is being generated by evaluations conducted by public health professionals and health care professionals, and how is this being used by managers, practitioners and policy makers?

This study aims to achieve an in- depth understanding of how staff who are implementing health programmes perceive and conduct evaluations while working within a primary care setting. This study aims to provide empirical data in order to offer an understanding of evaluation from the perspective of professionals involved in evaluation of locally implemented health programmes.

## Chapter Three

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### 3 Methods and Methodology

#### 3.1 Introduction

In this chapter, an overview of the research strategy will be discussed and described, starting with a description of the methodological considerations that were taken, followed by a detailed discussion and description of methods used to collect and analyse data in order to answer the research questions. Reflective accounts will be described in the methods to illustrate the researcher's awareness of the influence of the researcher role on interactions with participants and the research outcomes (Bryman 2012).

This chapter is organised into two sections. In the first, the research methodology will be discussed, including an explanation for why a naturalistic approach was chosen. The second section sets out the methods, including an explanation of the specific approaches used, in relation to selection of the setting and case study, recruitment of participant's data collection. It will also include in specific sections reflections on the ethical concerns, and the impact of being a participant observer whilst having an active role.

A qualitative research methodology informed by ethnographic approaches was used for the study, as the aim was to gain an understanding of evaluation from the perspective of the public health practitioners in their working environment. The researcher spent one year as a participant observer, working alongside public health professionals involved in the implementation of the Health Check programme in a Primary Care Trust (PCT). The NHS Health Check programme for cardiovascular disease was chosen as the case study to provide the context for exploring how public health professionals evaluate the programmes they are implementing. The Health Check programme was chosen because it was identified in the House of Commons Health Inequalities report as a programme that had the potential to be robustly evaluated (House of Commons 2009). The majority of data for the study was gathered from formal and informal interviews with the study participants. Available national and local programme guidance and policy documents were also examined.



### **3.2 Philosophical considerations**

In a study in which the views and perspectives of others are being explored, there needs to be an acknowledgement of the philosophical basis of the research strategy. This is necessary to enable the claims made of the data, and more broadly the nature of the social world that is being investigated, to be made clear (Carter and Little 2007). According to Proctor, the philosophical aspect of the research process is important because "it provides the grounding for the research methods within an accepted epistemological paradigm" (Proctor 1998: p73).

#### **3.2.1 Ontology and epistemology.**

The starting point of the research process suggests Seale (1995) is an awareness of ontological and epistemological orientations, and their impact on the research process and assumptions made. According to Gale (1993) a researcher's orientation provides the basis for their assumptions as it directs how they construct and represent the knowledge gained from the data that they have collected. This Guba (1990) explains, is because the researcher is aiming to present the reality of others through their own interpretation. However, Murphy et al (1998) notes that despite the need to explore and state these assumptions, it is not necessary for a researcher to "solve all philosophical problems before embarking upon social research" (Murphy et al 1998: p 64).

As this study is concerned with understanding and explaining how evaluation is done in practice from the perspective of health professionals, it can be argued that the viewpoint of the researcher is not relevant. What is more relevant is how the participants' view of their world is interpreted and presented by the researcher. The framework that a researcher uses to explore, interpret and represent the reality of others becomes important (Lincoln and Guba 1985). An epistemological viewpoint that enables the researcher to balance engagement with, and detachment from, the conceptual world of the community being observed is therefore appropriate for this study.

According to Denzin and Lincoln (2000), qualitative research is structured by four major interpretive paradigms; positivist and post positivist, constructivist interpretive, critical and feminist poststructural. Due to the nature of the research question, it would be reasonable to

acknowledge that different realities exist and a constructivist interpretative paradigm would be relevant to guide the research strategy for this study. A constructivist interpretative paradigm was chosen for a number of reasons; the researcher was interested in exploring the different viewpoints of health professionals in regards to evaluation and how they perceive evaluation as a process.

The approach adopted in this study was informed by a key definition advanced by Denzin and Lincoln (2000) as to the nature of qualitative research, both in terms of the methods (which will be considered later), but also in relation to the underlying principles of qualitative inquiry:

Qualitative research is multi method in focus, involving an interpretive, naturalistic approach to its subject matter. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret phenomena in terms of the meanings people bring to them. Qualitative research involves the studied use and collection of a variety of empirical materials – case study, personal experience, introspective, life story, interview, observational, historical, interactional and visual texts – that describe routine and problematic moments and meanings in individuals' lives. (Denzin and Lincoln 2000: p2)

This definition suggests that there are two crucial elements to qualitative methodologies that use a naturalistic approach. Importantly a naturalistic approach is one that is within the constructivist interpretative framework (Denzin and Lincoln 2000). A key issue in adopting a naturalistic approach is how much the researcher interacts with the participants when collecting data, and what influences this will have on the research process, interpretations and findings. The decisions regarding how the researcher interacts and reflects on their interactions are part of the research process. Charmaz (2004) argues that the nature of naturalistic inquiry means that there needs to be an acceptance that the researcher will invariably have some impact on processes and interpretations. She adds that it is therefore essential that there is transparency, and that this is achieved by providing a good description of processes, decisions, perceptions and reflections made during the research process in the final write up of the research. Nevertheless, the need to remain open is also a key aspect of this approach, which makes it suited to conducting research that explores human activities in a health service environment. Moreover, to gain insights into how staff perceive and do evaluation, an approach that is ethnographic allows the research to unfold (Baszanger and Dodier 1997).

### **3.3 Qualitative field study drawing on ethnographic methods**

There was little empirical evidence and literature found to provide insight into how evaluation is understood and undertaken by health professionals in a health service setting. It was therefore important to use an approach that enabled this to be explored in more depth. After considering the different approaches related to ethnographic methods including anthropology, the decision was to adopt Hammersley and Atkinson's (2007) position on the use of ethnographic approach. Ethnographic studies allow flexibility and for the incorporation of methods that would enable the research objectives to be met. Indeed, this plurality of methods was a particular attraction in using an ethnographic methods approach, and, as Fielding's (1993) definition indicates, two specific approaches in particular were adopted. The decision was made to adopt the,

“form of qualitative research which combines several methods including interviewing and observation” (p.54).

A qualitative approach was considered the most appropriate, as it permitted an in-depth exploration of the various issues identified by the research question, as to how evaluation is accomplished in practice in the context of a particular programme. The intention was not to undertake a full ethnographic study, as in Bate's (1997) broadest typology, but to draw on the methods and principles used in ethnography to guide the data collection process and inform the presentation of the findings. The researcher had the opportunity to spend time observing the participants as they went about their day-to-day activities and to become embedded in the environment that they inhabited.

This study can broadly be described as a qualitative field study, underpinned by ethnography principles and approaches. Hammersley and Atkinson (2007) have argued that it is acceptable to use ethnographic methods to collect data without having to ascribe to the methodological features that support a traditional ethnographic study. Combining these methods with an anthropological perspective, as Lambert (2002) notes, can strengthen the way in which ethnographic approaches can be used. As Lambert (2002) explains, anthropology has the right mix of theory and approaches required to engage in social research because it has developed techniques to analyse, interpret and translate socially and culturally derived information (Pelto and Pelto 1997).

The broad question for this research was concerned with understanding how a group of professionals perceived a specific activity, evaluation. The research method adopted in this study aims to provide the data and analysis to answer the following research questions.

1. How is evaluation perceived by public health and health care professionals working in a primary care setting?
2. How do public health professionals and health care professionals evaluate national programmes that they are implementing locally?
3. What information is being generated by evaluations conducted by public health professionals and health care professionals, and how is this being used by managers, practitioners and policy makers?

The overall aim was to understand evaluation from their perspective as well to gain insights about how evaluation is carried out in a specific environment. Therefore, a research approach was needed that allowed this understanding to be gained without a set of preconditions or without applying a predetermined theoretical framework to elucidate understanding. While this was not a research question that required the level of immersion of an anthropological study that aims to understand the cultural and social interactions with a community or environment (Bernard 2002), an ethnographic approach was considered most appropriate for this study. The main attraction of using ethnographic approaches was the ability to become immersed in the research setting, or being in the 'field' and use a mixture of methods to collect data to explain interactions, behaviour and perceptions that occur within the team or organisations (Reeves et al. 2008). The adoption of ethnographic approaches suggest Angrostino (2007), provides a formal and systematic approach to the data collection processes thereby making the observations empirical (Angrosino 2007 cited in Jones and Watt 2010). This approach would enable the researcher to understand how evaluation was perceived and conducted by staff in the specific service environment. This is particularly relevant to the first two research questions, which explicitly refer to the setting of 'primary care' in a 'local' context. In addition, such an ethnographic approach would allow the use of a range of methods to collect rich, in-depth data from different perspectives and to present the 'native' or 'insider view' (Labaree 2002).

The collection and analysing of data are interrelated and are carried out together throughout the research (Savage 2000, Bernard 2002). Openness extends to the nature of the relationship between the researcher and the participants. How this is fostered and maintained

will have an impact on several important aspects of fieldwork; acceptance, immersion and an accurate representation of observations. Continued negotiation with the organisations and participants throughout the research process is essential and considered good practice (Associations of Social Anthropologist 1999).

### **3.3.1 The setting**

The decision was made to explore evaluation within the confines of delivering the NHS Health Check programme in one PCT. There were several reasons for exploring how evaluation was perceived by professionals in the context of the Health Check programme. Firstly, it was thought that a better understanding of how health professionals perceive and carry out evaluation would be gained if explored in the context of a national programme being delivered locally. Secondly, the Health Check programme was specifically identified in the House of Commons report as a programme that had the potential to be robustly evaluated. In addition, the Health Check programme fulfilled all the necessary requirements for it to be evaluated. It was also a national programme with a high political profile the programme's implementation in 2008 was accompanied by the then Prime Minister's declaration that everyone would have access to a health check assessment.

The core aims of the programme were to use risk management strategies to control vascular disease. In 2006, Sir Muir Grey set out his view of how a vascular disease control programme should be developed and implemented in the UK (Grey 2006). He felt that there was a need for a coordinated approach to vascular disease control and for public health measures to focus on risk detection and management. He proposed the use of an integration of risk management programme to include four risk management strategies; self-assessment risk management, record based risk management, population based risk management and sporadic risk assessment and management.

In Grey's view, the key goals for a national programme should be prevention, early detection, treatment and management of those at risk. All activities of the programme should take place in the primary care setting with general practices playing a critical role in putting in place the mechanisms to detect, treat and manage those identified as being at risk of vascular disease. Lipids, cholesterol, diabetes and smoking were the main factors used to determine an individual's risk. Health care professionals of all levels should be engaged at all stages of the

programme. Individuals assessed as being at medium to low risk were to be given lifestyle advice or referred to smoking cessation advice, weight management and exercise programmes. Those at higher levels of risk would be offered medication such as statins and antihypertensives, and intensive lifestyle management for impaired glucose regulation.

The Health Check programme started life as the Vascular Control Programme in 2008. The UK National Screening Committee (NSC) published the Handbook for Vascular Risk Assessment, Risk reduction and Risk management which gave an overview of the theoretical principles, evidence with standard operational frameworks, and guidance for the programme (Davis et al. 2008). This strategic framework developed for vascular disease prevention presented the core characteristics of the programme. In 2009, the NHS Health Check programme was gradually rolled out across the country with a focus on the prevention of four related diseases: CHD, diabetes, stroke and kidney disease.

The objectives of the Health Check programme were to assess the risk of individuals aged 40-70 of having a cardiovascular event within 10 years and to provide appropriate treatment and advice based on the risk profile of the individual (Vascular Check Programme 2008) and Primary care service frameworks for vascular checks ( NHS Primary Care Contracting 2009). The expected impact of the programme, in addition to managing and reducing risk in the target population, was to play a role in reducing health inequalities in cardiovascular disease risk factors.

The programme was described as having the potential to "offer a real opportunity to make significant inroads into health inequalities, including socio-economic, ethnic and gender inequalities" (Vascular Check Programme 2008). This ambition for the programme was reiterated in the impact assessment of the programme and in the programme's economic modelling. Economic modelling (Vascular Policy Team 2008) indicated that the Health Check programme would have significant cost-effective benefits, by reducing risk factors associated with cardiovascular disease such as smoking, cholesterol and obesity, and therefore reducing treatment costs for cardiovascular diseases in the population. Importantly, the programme was described as being able to achieve a reduction in the prevalence of Coronary Heart Disease (CHD), diabetes, stroke and kidney disease in the population.

It was further indicated that the programme had the potential to have high levels of both clinical and cost effectiveness against a range of assumptions and estimated that the programme eventually could:

- prevent at least 9,500 heart attacks and strokes a year (2,000 of which would have been fatal)
- prevent at least 4,000 people a year from developing diabetes; and
- detect at least 25,000 people a year earlier with diabetes or kidney disease.

(Vascular programme 2008: p 9)

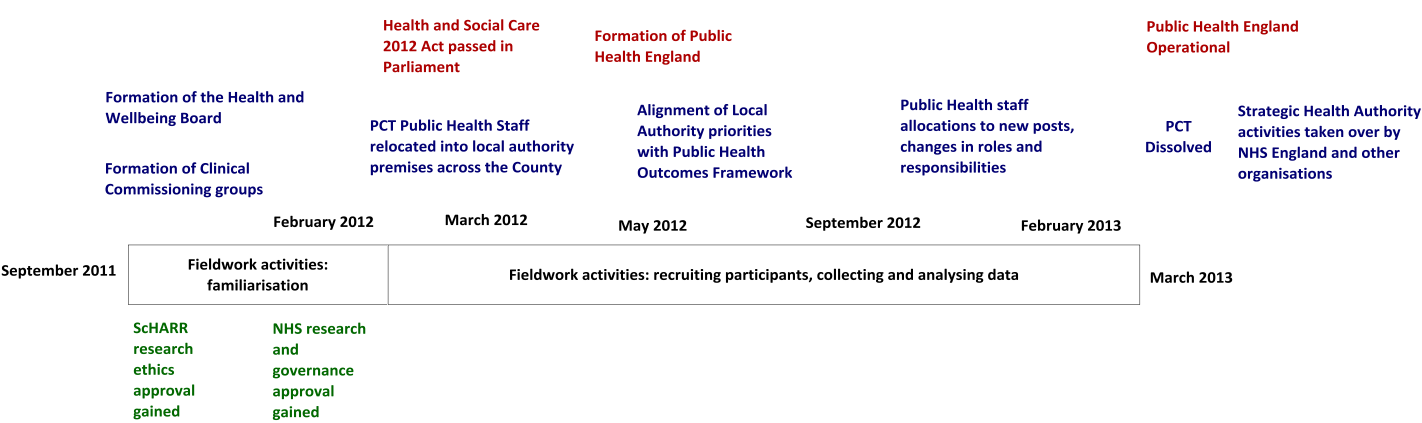
Taking all of this into consideration, the Health Check programme has the key characteristics for a robust evaluation to be carried out in order to generate the necessary analytical information to inform policy and demonstrate impact. The rationale for the programme was clearly presented in the vascular assessment and management handbook (Davis et al 2008) and the aim, objectives and outcomes of the programme were set out. An economic modelling of the programme potential impact had been commissioned and illustrated the potential effectiveness of the programme in term of its impact on health outcomes and savings in cost. This included the programme's potential achievements in terms of reducing health inequalities. Health Check programme had all the necessary factors for it to be robustly evaluated.

The PCT was chosen as the ideal setting to observe public health and health professionals as they engaged with activities related to evaluating programmes they were implementing. In particular, activities related to evaluating a national programme being implemented locally. Importantly, the public health and health professionals within this PCT were in the process of both implementing and evaluating the Health Check programme. In addition, the researcher was previously a member of the public health team. This facilitated access and understanding of specific local issues that might influence approaches to the programme, its delivery and its evaluation.

However it is important to note that the time the researcher was in the field engaged in research activities that this was a period of significant change within the NHS. The timeline represented in Figure 2 shows the researcher activities in the context of the policy and organisational changes that were occurring and the participants were experiencing. The changes taking place during this time were due to the introduction of the Health and Social Care Act 2012. Part of the introduction of the Health and Social Care Act was the formation of new organisations

and changes in public health functions, roles and responsibilities. It was anticipated that these changes would have a great impact on those working within PCTs and, in particular, for those working within public health directorates. In preparation of the changes, staff in the public health directorate were made aware that their roles and responsibilities would be changing, as public health functions and activities were going to be taken over by organisations outside of the NHS. They were also aware that this would mean relocating to other premises and potentially having to work across different geographical areas.

**Figure 2: Fieldwork Timeline: Policy and Organisational Changes**



### 3.3.2 Familiarisation

Familiarisation is an important step in the qualitative research process, when a researcher plans to spend a substantial period of time in the field (Bernard 2002, Hammersley and Atkinson 2007). Familiarisation provides the researcher with the opportunity to explore expectations with prospective participants, negotiate roles and gain the necessary permissions (Bernard 2002). A period of familiarisation, according to Bernard (2002), gives the researcher time to get an understanding of the structures in place. It is also the period to determine boundaries and to establish relationships with potential participants. It is an important stage in a field study, as engaging potential participants at this stage of the process before data is collected is necessary for enabling the establishment and building of trusting relationships with potential participants. Spending time with and working alongside public health professionals within a primary care trust



in the United Kingdom (UK) formed a major part of the study approach and the period of familiarisation was an integral aspect of the research process.

The familiarisation period fulfilled two functions: firstly to have the time to obtain the necessary permissions to carry out research in the organisation, and secondly, to spend time developing a better understanding of structures and putting arrangements in place to determine the parameters for the research. The familiarisation phase started two months before the data collection commenced.

It was necessary, for example, to become an honorary member of staff before being able to obtain the necessary permission to take part in organisational activities. It was during this period that ethical approval submissions were made to University of Sheffield and the NHS Research and Ethics Committee and approval was obtained from the organisation's research and governance team to carry out research in an NHS organisation.

The researcher then engaged in open discussions with potential study participants about the research topic. It was during this period that potential participants asked questions about the research, had the opportunity to discuss and agree their level of involvement, and explored what level of participant observation was acceptable. The researcher was invited to attend two of the NHS Health Check programme task group meetings to present the research proposal to the group. At these meetings, the reason for doing the study was explained. Due to the nature of the research approach, it was necessary for members of the group to have the opportunity to give their views about the researcher's level of involvement, the practicability of the researcher becoming an active member of the group, getting involved in day-to-day activities of delivering and evaluating the Health Check programme. The potential participants offered suggestions about the wording for the information sheet and consent form, as these needed to reflect the agreed level of engagement and involvement the researcher would have with the delivery of the Health Check programme. These meetings also provided an opportunity for the researcher to get to know the potential participants better, and to start to build a rapport with them before fully entering the field and becoming involved as an active participant observer.

Members of staff at the meetings expressed an interest in the research topic and gave verbal consent that they would be happy to be involved once official permissions were obtained. It was agreed that an honorary contract would be sought and support would be provided to enable this to be obtained. Once the official permissions were obtained the researcher would join the task group to support the delivery of the Health Check programme. The lead public health

consultant and senior manager for the programme would identify suitable tasks for the researcher.

### **3.3.3 Obtaining ethical approval**

A study in which the researcher spends a significant amount of time with those who they are studying poses a particular set of ethical issues (Murphy, Dingwall et al. 1998; Pope 2000; Goodwin 2003; Hammersley and Atkinson 2007). Within any study, a number of different ethical issues can arise, and these may be difficult to predict before starting the study. What was important were the strategies used to resolve these issues when ethical dilemmas do arise. Ethical dilemmas are not restricted to the period in the field collecting data, but may occur at every stage of the research process (Bernard 2002). To be prepared to address them when they occur, Murphy et al (1998) suggests that having an ethical framework can help guide the decisions that will have to be made during the course of the study. There are a number of frameworks that can be drawn on to provide guidance, but commonly, within health related research a framework underpinned by deontological principles can be used to guide decisions to resolve any ethical dilemmas (Murphy et al 1998).

To carry out this study in a PCT both ethical approval and PCT research governance permission was required. Ethical approval for the study was obtained from the School of Health and Related Research ethics committee, since it was no longer necessary to have NHS ethical approval for studies involving staff. However, it was still necessary to gain permission to carry out research in NHS premises and meet the PCT's research governance requirements. The anticipated ethical issues in this study were largely ones that were concerned with privacy, the preservation of participants' identity and informed consent (which will be discussed in more detail in the following section [3.3.4](#) ). The researcher ensured that potential participants for this study had opportunities to gain as much information as possible in advance about their level of involvement and the purpose of the study. Primarily this was done in consultation with potential participants, in initial discussions about the study design, the research boundaries and the level of their involvement, including how certain types of information would be treated.

As the researcher had worked in the PCT in the past, there was the potential that personal and private matters would be raised during the interviews with participants. Respecting their privacy was a factor, the researcher had agreed not include parts of the conversations that were

personal and unrelated to the research topic in transcription. Preserving the identity of participants had to be taken into account; this was one of the PCT research governance requirements, as well as something that the researcher had agreed with the participants. Minimal personal identifiable information would be collected as participants joined the study, and no identifiable information will be included in the final report. Maintaining confidentiality was also an issue that was discussed. It was agreed that the researcher would not have access to personal identifiable or confidential patient information, as this would be breaching confidentiality.

### **3.3.4 Recruitment of participants**

Bernard (2002) describes two kinds of data used in social research individual and cultural. Cultural data is information on views about processes, for example explanations about events, whilst individual data is about attributes, such as age and gender. He suggests that if researchers are interested in collecting individual data, then they would need to select a sample that is representative and use probability sampling. On the other hand, if they are collecting cultural data, there is no need to have a representative sample, and a non-probability sample is appropriate.

The research topic and question determines the level of the unit at which the data needs to be collected. There were two important considerations to be taken into account when deciding whom to recruit for this study. Firstly, the participants needed be representative of the professional groups that would typically be involved in delivering a public health programme within a primary care trust environment. Secondly, they needed to be professionals who were actively involved in some aspect of delivering and evaluating the Health Check programme.

The potential participants for the study were the public health and health professionals involved in implementing and managing the delivery of the NHS health check programme for the PCT, and were all NHS employees. The participants were selected on the basis of being typically representative of professionals working within public health departments in primary care trusts. In addition, it was identified that staff involved in delivering and implementing the evaluation of the NHS Health Check programme were a diverse group, and included consultants in public health, programme managers, health informatics managers, public health commissioners, public health specialists, healthcare assistants and practice managers.

An additional reason for recruiting professionals working within a primary care trust was their shared role in planning, implementation and evaluation of a specific complex public health programme. They all therefore had specialist knowledge and skills that were relevant to the research topic. The participants' roles and responsibilities for their positions were based on national generic job profiles (Appendix: two for details of criteria) that spread across the nine NHS Agenda for Change (AfC) grades and pay bands.

The nature of the setting and the researcher's knowledge of the participants' roles and her involvement with delivering the Health Check programme meant that a combination of purposive and snowballing sampling approaches was used to select the participants for the study. Using a purposive sampling approach to selecting a particular group representative of the group of interest is justifiable when the research question is on a specific area or topic (Hammersley and Atkinson 2007). In a study such as this, in which the views and actions of the participants are the focus, it is common to use a sampling approach in which selection of participants is based on their competence and knowledge of what is being explored, rather than recruiting a sample that is statistically representative (Bernard 2002).

Purposive sampling allows the researcher to use their judgement to determine the suitability of potential participants, and this tends to be based on the participants' knowledge of the research topic (Bernard 2002).

The participants' involvement in the research was determined by a number of factors: the participant's role in the organisation, the level of their involvement in the NHS Health Check programme, their willingness to take part in the research, including any new avenues being explored as the research themes emerged. This implies that it would not have been possible to determine at the beginning of the study how many, or which, participants would be included in the study. This only became clear after the fieldwork and the data collection process had started.

The sampling strategies for the selection of participants were carried out in two phases. In the first phase, purposeful sampling strategies was used to guide the selection of participants for the initial sample, participants were chosen because they were judged as being able to provide relevant information and they were a convenient group for the researcher (Marshall 1996, Patton 2002). In the second phase, theoretical sampling strategies were used to guide the selection of participants. At this stage of the study, theoretical sampling enabled participants to be chosen on the basis that they could provide more relevant information, contributing to the building of the concept or theory being constructed (Glaser 1965, Patton 2002). The selection of

participants for this phase of the data collection was directed by the emerging themes which determined where and who the data should be collected from.

Part of the process of gathering more information about the emerging themes was to draw on the perspectives and experiences of others who were in the setting but were not part of the original sample, as they could potentially offer a different view. A combination of approaches, such as deviant case, opportunistic and intensity sampling, enabled different sources of data to be identified and collected (Marshall 1996).

The recruitment of participants would be through a key informant, who would identify individuals who were involved in aspects of the programme planning and implementation. The lead public health consultant for the programme acted as a key informant and identified the members of staff who were involved in delivering and managing the programme. It was agreed that he would not approach staff directly to ask, or be involved in the recruitment of participants.

The condition for gaining ethical approval for the study was that each potential participant had to be given an information pack, which included the research letter, information sheet and consent form (Appendix 1). It was also a condition that participants had 24 hours to think over their involvement. The need to ensure that the participants had at least 24 hours to read the research information before agreeing to take part and sign the consent form was viewed with some amusement by the potential participants. Most of participants were familiar with the study and the nature of their involvement as this had been discussed during the familiarisation period. While the potential participants were comfortable with giving verbal consent, it was necessary that the agreed organisational protocols that required each potential participant to sign an informed consent form were met. The potential participants were sent the research information by email and asked to contact the researcher if they had any questions. All participants had the opportunity to read the research information and ask questions before they signed the consent form. However, as most of the study participants had already indicated their interest in taking part in the study during the familiarisation phase, they did not think it necessary to wait for 24 hours before consenting.

However, the researcher did still ask potential participants to read the research information sheet and the consent form before they agreed to take part in the study. It was explained to participants they were consenting to the researcher observing their work activities for the whole of the data collection period. After they had agreed to be involved, consent would be assumed, unless it was otherwise indicated. It was explained that they could temporarily withdraw from periods of observation or fully withdraw from the study if they considered the

researcher's presence to be intrusive or disruptive. It was also explained that they could withdraw consent at any time without having to provide a reason. Participants were made aware via the information sheet and consent form that data, once transcribed and anonymised, would be used in the final analysis even if they had decided to withdraw permanently from the study.

Over the time spent within the PCT, sixteen health professionals of varying roles and experience were recruited as participants for the study. The participants were recruited in two phases, which were dictated by individuals' attendance at the Health Check meetings, and availability of the individuals identified by the key informant as being involved in aspects of Health Check programme.

In the first phase, seven participants were recruited. Data analysis started as soon as data was collected and put in a format to be analysed. Recruitment of participants stopped once there were seven study participants. In this first phase, the recruited participants PHL1, PHL2, PM3, PM4, PM2, CM1 and PHA1 were the individuals that the researcher had the most contact with during her time in the field. Three further participants were recruited in the second phase based on themes that were emerging. Participants PM6, PM7, PHL3 who still had some involvement but not involved in the daily management of the programme were recruited during this phase. It became apparent that not all the members of the Cardio Vascular Disease (CVD) task group were involved with the day to day activities of the programme. However, the key informant explained that because they were involved in some aspect of the programme at different levels and points in time they could provide a different perspective to the evaluation. The other study participants were individuals that attended the CVD meetings irregularly and contributed mainly to the strategic management of the programme.

**Table 1: Study participants**

Study participants phase 1 recruitment		AfC band	Study participants phase 2 recruitment		AfC band
PM1	Project manager	Band 6	PM5	Health Improvement manager	Band 7
PM2	Health Improvement Manager	Band 7	PM6	Health improvement manager	Band 7
PM3	Health Check Programme Manager	Band 7	PM7	Health check programme manager	Band 6
PM4	Public Health Analyst	Band 7	CM3	Clinical Commissioning manager	Band 7
CM1	Clinical Commissioning Manager	Band 7	CM4	Clinical Commissioning manager	Band 7
PHL1	Public Health Consultant	Band 8	CM2	Clinical Commissioning manager	Band 8
PHL2	Public Health Consultant	Band 8	PHL3	Public health Consultant	Band 8
PHA1	Administrator.	Band 4			
RM1	Public Health Regional Manager	Band 7			

As mentioned in the above section on the importance of obtaining ethical approval in field studies, gaining informed consent is an issue that had to be addressed. It is recognised in field studies that are ethnographic that the recruitment of participants can depend on who is available at a particular time and the situation in which they are being asked to take part. Therefore, obtaining consent was one aspect of the recruitment process that required careful consideration, particularly when participants are members of the organisation who sanction the research in the first place. The researcher in these situations has a duty to ensure that potential participants understand what the research is about and have agreed for data to be collected from them without any form of coercion. In this study, it was agreed that participants should enter into the research fully aware of what their involvement would entail.

However, staff movement into new roles and changes in their level of involvement in the programme presented a particular challenge. With an understanding of the fluid nature of the workforce in the public health department in mind, the researcher made sure that steps were taken to ensure that all potential participants were fully aware of the study and what it was about and what their level of involvement would be before they agreed to take part. The information

about the study was included in a newsletter that circulated to all staff who were involved in the Health Check programme. In addition, the researcher attended two meetings to explain the project to the members of the CDV task and invited these members share their views and concerns about the research topic. Once the recruitment of participants had started, all potential participants were given an information sheet that gave them full information of what their involvement would involve. Potential participants were asked to comment on the information sheet to ensure that what was being asked of them was clear.

It was important to ensure that participants had the ability to make choices about their level of involvement at all times, and felt comfortable to indicate when they did not feel it was appropriate for a particular interaction or conversation to be recorded for research purposes. It was also important that participants did not feel obliged to take part simply because they were worried about impact that refusing to participate may have on their relationship with the researcher. In these situations, it is acknowledged that it can be hard for participants to feel that they can withdraw their consent in a study in which the researcher is embedded in the community (Bernard 2002). It was therefore important that participants were never put into a position that prevented them from being able to decline to take part at any time during the process. The researcher also ensured that it was a collective decision to allow the researcher to become a part of the group and to have an active role in their activities.

A further strategy adopted by the researcher was to indicate when material was being collected for research purposes. This was done by enabling the recruited participants to have the opportunity to indicate if they wished to take part or not at the beginning of any observation period. This is a common dilemma facing researchers undertaking qualitative field research, determining how often they should continue to seek permission to record conversations and make notes once informed consent has been gained at the onset of the study. In the Association of Social Anthropologists guidance (Association of Social Anthropologists (Associations of Social Anthropologist of the UK and the Commonwealth 1999), it is proposed that this consent should not be considered as a one-off event, and that verbal consent should be sought on a daily basis from participants. Others such as Bernard (2002) argue that this is not always necessary as it could disrupt the flow of the conversation.

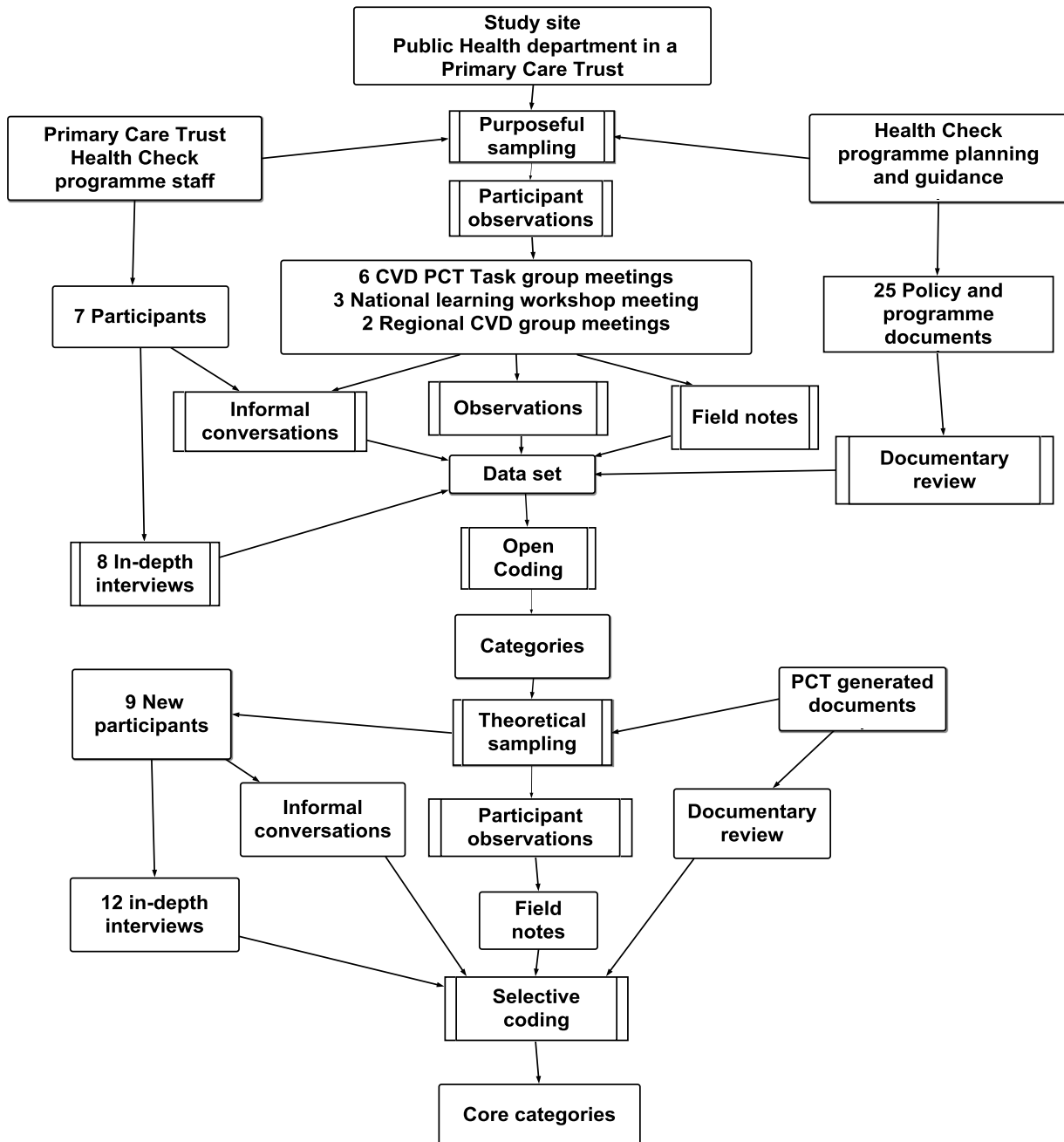
The approach that was taken in this study was to obtain verbal consent each time data was being collected after the initial consent was obtained. However, there were a few occasions when verbal consent was not obtained by the researcher, as it would have affected the flow of the conversation and important points would not have been captured. This happened after a



couple of months of being in the office. Gradually it was recognised that verbal consent was not necessary to be obtained every time that notes were being made for research purposes whilst in conversation. Instead non-verbal cues were deemed as suitable indicators of agreement. This also was extended to the intention to audio-record conversations, as it was made obvious by the researcher that the conversation would be audio-recorded. If no objection was made and the conversation continued, the researcher took this as agreement to continue. As all the participants were senior members of staff with high levels of autonomy the researcher was confident that they would, if they wished, withdraw, ask for notes or request that recording not to be done in situations which they deemed not to be appropriate. In one of the CVD meetings this did happen. This researcher was asked to stop the audio recorder as the topic being discussed was deemed as sensitive by the participants. There was another occasion when the researcher was asked to ensure that a section of the conversation at the meeting was removed from the transcript as the information was considered to be outside of the remit of the research topic.

One participant indicated after consenting that she did not wish to take part in the interviews and the reason she gave was that she did not feel she knew enough about the topic under review to be useful.

**Figure 3: Study Methods**



### **3.3.5 Documentary review**

The first set of data collected for the study was the documentary material. It was decided that documents used and produced by participants were themselves important sources of data. A review of the programme documents and material would also add to the richness of the observation and interview data, potentially providing another perspective (Bernard 2002, Miller and Alvarado 2005). Both the formal and informal documents produced and used by PCT staff were therefore considered to be an important form of data. It was decided that the material available to the staff within the PCT would be reviewed in relation to evaluation in general, and more specifically in relation to evaluation of the Health Check programme.

All the relevant documentary materials for the review were taken from the PCT SharePoint drive that was set up for all the staff who were implementing the Health Check programme in the PCT. The SharePoint drive was an internet document storage and sharing facility, which was set up by the member of the CVD task group to serve as repository for all the policy and guidance documents associated with delivering the programme.

The SharePoint drive held a mixture of national and local policy and guidance documents, as well as other documents related to the Health Check programme and the management of cardiovascular risk. All of this material was included in the documentary analysis. The drive also held all the CVD task group meeting minutes and other generic evaluation guidance documents published by NICE and the Medical Research Council (MRC). Some material on the drive had been accessed by web links to ensure that the most recent policy and guidance documents could be uploaded. The documentary analysis formed part of the familiarization process which informed the researcher's understanding of the various professional groups' involvement and the organization of the Health Check programme. Documents associated with the implementation processes and the evaluation of the programme were analysed before the interviews and observational data were collected.

### **3.3.6 Interviewing**

In a field study such as this, in which the researcher was spending a considerable amount of time with the participants, it was possible to use a mixture of interview techniques (Hammersley and Atkinson 1998). A mixture of formal and informal, ranging from spontaneous, informal conversations to formal arranged in-depth interviews were used in this study. This mixture of interviewing approaches enabled the collection of a rich data set that facilitated in-depth insights about how evaluation was perceived by participants. Semi-structured interviews are a recognised data collection tool in studies that are interested in gaining insights into how individuals work (Silverman 2010). Semi-structured interviews are used primarily to explore perceptions of individuals and to get an insight about their experiences of evaluation.

All of the study participants were invited to take part in an initial, semi-structured interview. These and subsequent interviews with the participants, were arranged outside the main office hours and formed the majority of the research data. These interviews were carried out between February 2011 and April 2012 at times that were convenient for the participants and in total 20 semi – structured interviews were carried out. The semi- structured interviews focused both on evaluation in general and evaluation in the context of the NHS Health Check programme. An interview guide was used during the first set of interviews to ensure that key points relating to the research questions were not missed. However, in order to enable participants to talk openly about evaluation, it was often necessary to allow the participants to continue without interrupting. The opening questions and probes during the interviews resulted in interview data that covered all the topics in the interview guide and more. The interview guide was used as an aide memoir and was not used to direct the interview, as this would have interrupted the flow of conversation. It was used instead by the researcher to check that areas relevant to the research questions were discussed.

In addition to the material from the semi-structured interviews, data was also collected from spontaneous and informal conversations in which evaluation was being discussed, outside of the formally arranged interview sessions. These informal encounters generally originated from casual conversations with participants in the office. They were informal and opportunistic, and provided additional insights, since they tended to reflect the individuals' personal perspectives and attitudes to the evaluation of the Health Check programme. Material from these informal guided conversations and spontaneous interviews provide an additional level of insight that may not have been captured during formal interviews (Baszanger and Dodier 1997). These

unstructured interviews provided reflections that were more personal and tended to cover a broad range of issues relating to evaluation, including evaluations of other programmes participants were involved with. Data collected from informal conversations were not audiotaped, but notes were made during the conversations that were written up in the research diary at the end of each day.

The emerging categories from the analysis of the first six interviews were used to inform what was asked in interviews with subsequent participants and in follow up interviews. A second set of semi-structured interviews was carried out with four of the initial participants and these allowed the collection of more data that was relevant to the study's emerging themes.

### **3.3.7 Participant observation**

Participant observation is becoming a common method to collect data in health related research (Savage 2000). Its participatory nature enables the researcher to gain a greater understanding of the perspectives of those being studied (Hahn 1999). Within the over-arching term of "participant observations", there are a number of specific types of potential observation methods related primarily to the degree of involvement of the researcher. These methods are divided into participant and non-participant observation approaches. The observer role can be either overt or covert and with varied degrees of interaction with participants, ranging from no interaction to having an active role and becoming a member of the group being studied (Bernard 2002). Participant observation usually involves the researcher being active and typically contributing to the setting, either by undertaking the same or a similar role to those being observed, or another role that may be different but still involves related activities or contribution. Non-participant observation is characterised by the absence of the researcher's involvement. Gold (1958) classified participant observation into four roles based on the level of researcher participation (Table 2)

**Table 2: Participant observer roles**

<b>Role of Participant Observer</b>	<b>Description</b>
Complete participant	Fully functioning member of social/political setting. True identity of researcher is not known to members of setting.
Participant as observer	Fully functioning member of social/political setting. True identity as researcher is known to members of setting.
Observer as participant	Researcher is largely an interviewer. Observations are done with little participation.
Complete observer	Researcher observes and does not interact with people. Researcher is unobtrusive.

In participant observation, the main issue being explored remains at the centre of the research. The common barriers to participant observation are access and acceptance. Hammersley and Atkinson (2007) recommend that negotiation and familiarisation should start before fieldwork begins, as this will help with both gaining access and being accepted. Participant observation in a setting and with a group that the researcher is already familiar with can help to overcome these barriers (Bernard 2002) and, as the previous section on setting indicates, this was the approach that was used. However, the researcher was also entering the setting as a 'privileged participant'. A privileged participant is someone who has insider knowledge of the research setting, usually through some past professional or social association or is known to the potential participants. Labaree (2002) explains that researchers who have already had contact or were once part of the group that they are entering as an insider has advantages and disadvantages. The main disadvantage is maintaining objectivity, not becoming too immersed or losing the researcher's outside perspective. This is a common concern with studies in which the researcher is an insider (Labaree 2002). To address these issues, the researcher continually made reflective notes, and recorded personal feelings and reactions to situations. This all formed part of the part of the research and data collection strategy. It also contributed to the reflexive approach to data collection in the study, which is discussed in more detail later.

The participatory approach used in this study allowed the researcher to undertake activities which would ultimately benefit the PCT (which was funding the research through a PhD

studentship), and drew upon the researcher's public health experience. As a participant observer, the aim was to get an insider view of how evaluation was perceived and conducted by professionals. Therefore, having an active role and becoming an accepted member of the group was considered essential. The researcher spent on average three days a week in PCT offices between September 2011 and March 2013, actively engaging in tasks related to the delivery of the Health Check programme and research activities. This period included the familiarisation period. During whole fieldwork period, the researcher had an active role and was involved in activities associated with delivering and managing the Health Check programme.

As part of direct observations, the researcher attended six CVD task group meetings, and two regional meetings. Three of the task group meetings were audio recorded as all present were recruited as participants in the study. Notes were taken during the other meetings, as individuals who had not been recruited had attended the meeting, as a decision had been made to only audio record meetings if all those present were study participants. The researcher also attended three national learning workshops one national evaluation meeting and one national meeting on behalf of the CVD task group. The notes made at these meetings were reflective in nature and were not incorporated as part of data analysis. However, they are included in the discussion section as they informed the interpretation of the wider implications of the study's findings.

Field notes are a key data collection method used in ethnographic studies and form an important part of the research data included in the analysis (Bernard 2002). While notes made during observations are a record of what has been observed, they also served as a record of the researcher's feelings and thoughts (Mulhall 2003). Keeping field notes was one of the main methods used to record the observations while in the field setting in this study. The field notes for this research consist of the following:

- Descriptive notes - including jottings, a log of observations and a description of activities.
- Methodological notes - notes on the techniques used to collect data, including notes on arrangements and self-analysis.
- Analytical notes - recordings of ideas and thoughts to be used in analysis and writing up data.

Jottings and notes were made while attending the task group meetings and during the periods of observation in the PCT, spending time with the members of the CVD task group. Notes were written up fully at the end of each day. Notes and observations were made only when

activities or conversations were related to evaluation or evaluation of the Health Check programme.

Notes were also made when the participants were being interviewed and during meetings. These served to provide the context for the interview when they were transcribed. Any notes made during the day were typed up in full in the research diary in the evening. These field notes did not form a substantial body of data for analysis, but were a record of the key interactions that were relevant to the study occurring during the meetings. The reflections made about the involvement of the members of the CVD group were another form of data used to provide an understanding of the context. It was not always possible to make notes and there were times when there was very little to record, therefore notes were not always made.

### **3.3.8 Transcribing the data**

There are several debates about where the transcription of data sits within the research process. A researcher can choose from number of methods and approaches to transcribing data. Tessier (2012) points out that for some researchers, such as Duranti (2006), the transcript is considered a form of analysis. Their view is that once the event in which the data was collected is over, any process that involves the data becomes part of the analysis. This is also how Bucholtz (2000) views the transcription process, adding that some level of subjectivity will be included in the transcriptions. If a transcript is viewed by different people, with different theoretical lens, the content would be viewed differently. Included in the debates about transcribing data is the discussion around whether researchers should employ others to transcribe audio recordings.

A decision was made to have someone else transcribe the interviews that were carried out for this study. This decision was made primarily because the time required to transcribe the material would have meant spending less time in the field at a crucial stage of the research process when the researcher was being embedded into the team. All the interviews were transcribed verbatim and corrections were made by the researcher. The transcripts were checked a number of times. It was through this process of listening to the interviews and making corrections that the first stage of the analysis began and the first set of ideas emerged that later would inform development of coding categories.



### 3.4 Analytical methods

The analysis of data was informed by the principles and techniques of grounded theory as set out by Glaser (1978). Bernard (2002) explains that grounded theory approaches are widely used to analyse ethnographic data. Bernard (2002) describes grounded theory as an iterative process which uses a set of techniques to identify categories and concepts that emerge from the text, and to link concepts into substantive and formal theories. Grounded theory research is based on inductive coding of data (Bernard 2002). The steps set out by (Bernard 2002: p 463) were used as the guide for the analysis of the data.

1. Produce transcripts of interviews and read through a small sample of text.
2. Identify potential analytic categories and potential themes that arise.
3. Pull all the data from the categories together as the categories emerge and compare them.
4. Think about how categories are linked together.
5. Build theoretical models by using the relations among the categories by constantly checking the models against the data, particularly against negative cases.
6. Present the results of the analysis using exemplar quotes from interviews that illuminate the theory.

Grounded theory methodologies have been adopted as an analytical tool in many social research areas such as ethnography and health services research (Bernard 2002). However, it is recognised that using an analytical approach that draws on the principles of grounded theory to provide structure and rigor to analyses of data in qualitative field studies may not be fully endorsed by all social researchers. Many studies, in which the focus has been on gaining an understanding of how a phenomenon is perceived, have also drawn on grounded theory methodology as an analytical tool, without using it to develop a theory, but purely as a guide to provide a structured approach to the analytical process.

Jabareen's (2009) study, for example, demonstrated an alternative application of the methodology in the context of understanding how professionals perceive phenomena, illustrating how it can be used as an analytical tool without doing a "full" grounded theory study. This

particular study drew on a grounded theory approach to develop a conceptual framework that provided an understanding of environmental professionals' perceptions of sustainability. Jabareen (2009) suggests that this approach to data analysis is not only an appropriate method for building concepts, but also argues that grounded theory methodology provides a systematic approach to developing concepts from the data. Jabareen (2009) adds that it is one that "conforms to the good science model" (Denzin and Lincoln 1994, cited in Jabareen 2009: p .52). A grounded theory approach to data analysis, Jabareen argues, enables the researcher to form concepts from their data and provides a representation of the different realities in existence.

Jabareen (2009) defines a conceptual framework as a "network or "a plane" of interlinked concepts that together provide a comprehensive understanding of a phenomenon. He goes on to explain that the construction of a conceptual framework relies on conceptualisation and the building of concepts from the data. He based his definition of a concept on that proposed by Deleuze and Guattari (1994). Deleuze and Guattari view a concept as having many interconnected components. This study also illustrates how grounded theory methodology can be utilised as an analytical tool, and that it can be adapted and used to generate concepts to explain and understand a phenomenon.

In other examples, elements of grounded theory methodology have been used to provide a framework to analyse data and form concepts. In the study done by Diefenbach (2006), an analytical method based on the principles of grounded theory was used to develop a typology of tacit knowledge and use of intangible resources. Both this study and Jabareen's illustrate how the techniques and approaches of grounded theory can be utilised as analytical tools in studies in which generating a theory was not the primary purpose of the study.

#### **3.4.1 Constant comparison analysis**

The process of the constant comparison method proposed by Glaser (1965) was used to guide the analytical process in this study. This method enables both an inductive and deductive approach and whilst it is not a method that is exclusive to grounded theory, it has had a long tradition of use in anthropology and ethnographic studies (Bernard 2002)

The constant comparison approach, argues Glaser (1965), removes the use of the pre-conceived ideas and in this study the first stage of the process (steps 1 – 3 of the constant

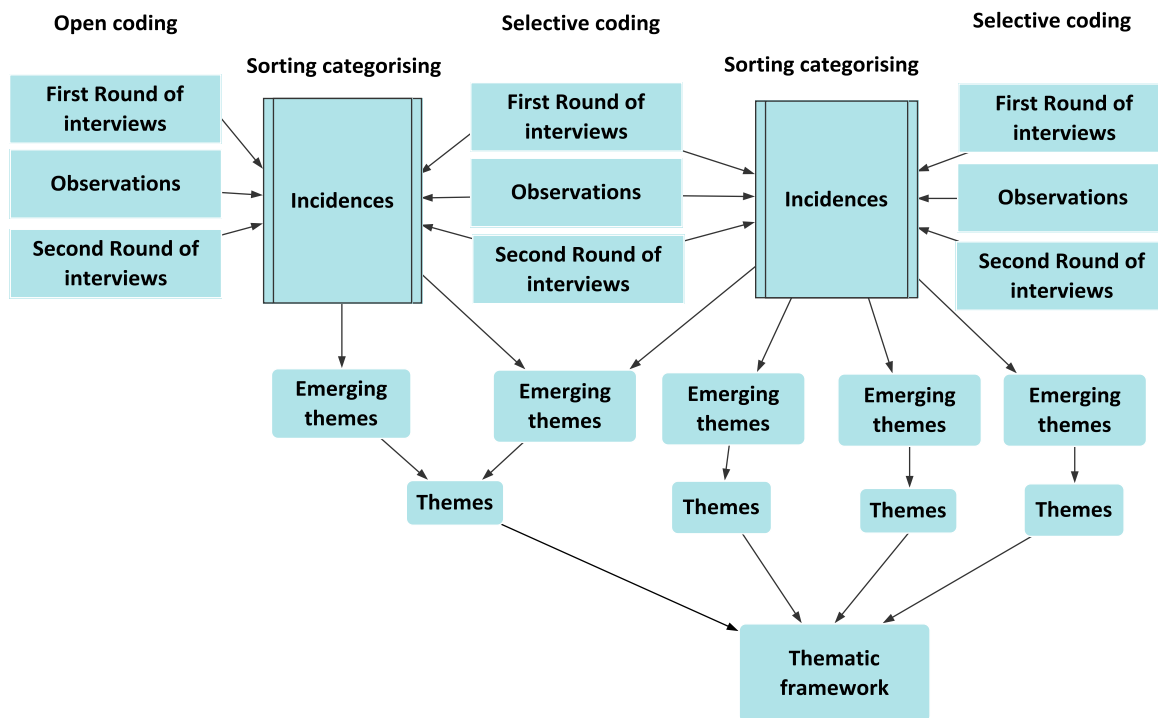
comparison method as described by Glaser) were followed in order to sort the data and to build the initial themes. These themes, through conceptualisation and theorising, formed the core categories or main themes that were then used to explain how evaluation was perceived and to provide an understanding of what was occurring, from the perspective of the participants.

The outcomes of the analytical process were then used, not only to provide an understanding of how evaluation was perceived, but also to offer a description of how evaluation was being conducted in practice. Therefore, the analytical approach used had to be one in which the participants' conceptualisation of evaluation could be presented, as well as enabling a description of context in practice. It was also necessary that the analytical approach was one that enabled the relationship between the themes to be identified and explained to gain a better understanding of evaluation.

The data analysis process was concurrent with data collection and the categories and theoretical notions which emerged from this process. The first two interviews were analysed as soon as they were transcribed. NVivo9 was used to assist organisation and coding of data. The open coding process generated a large number of categories that were subsequently compared and re-sorted. The emerging categories guided the analytical process and subsequent data collection. In the first coding cycle, Nvivo9 was used to code the data. It was during the first cycle of coding that memos were created to capture any thoughts that were triggered by the data (Glaser 1978). A process of comparing, classifying and theorising was then carried out during the second stage of the analytical process (Saldaña 2012).

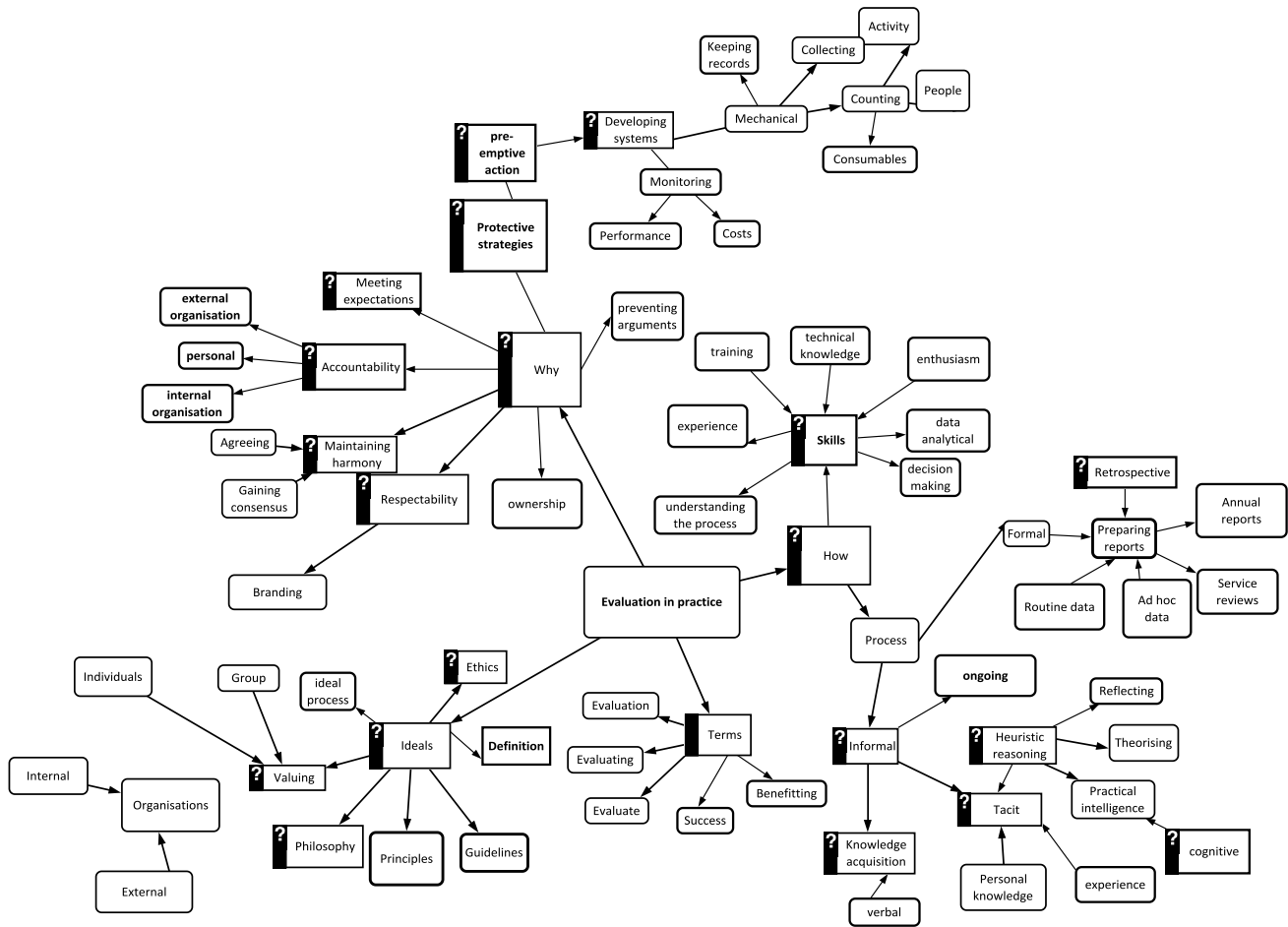
The initial coding of the first six interviews generated a large volume of coded material. Both full sentences and smaller elements of dialogue, generated by the open coding process, formed the units of data or incidences. These were then exported into Excel to facilitate the sorting and searching that is part of the constant comparison approach. It was through this constant sorting and checking, looking for similarities and differences between the units that the patterns which subsequently became the themes emerged. These emerging themes were used to inform the next stage of data collection and to inform the focus of the next round of interviews. Figure 4, shows the analytical cyclical process that was used as part of the constant comparison approach and how this led to the development of the themes.

**Figure 4: Analytical process**



Excel proved to be an effective way to facilitate the constant comparison process, comparing and sorting the segments according to similarities and differences. Core categories were organised into the themes that through further analysis provided an explanation for how evaluation is perceived from the perspective of participants, illustrating why evaluation is carried out the way it is in a PCT environment. The following diagram (figure 5) shows a map of the categories that emerged after the incidences were labelled during the level one open coding stage of the data analysis. The process was continued by adding new material from additional interviews, observations and notes alongside the material that was previously collected. Selective coding was then used to generate additional material, returning to the data to code material as new categories were created.

**Figure 5: Open coding emerging themes**



### 3.5 Summary

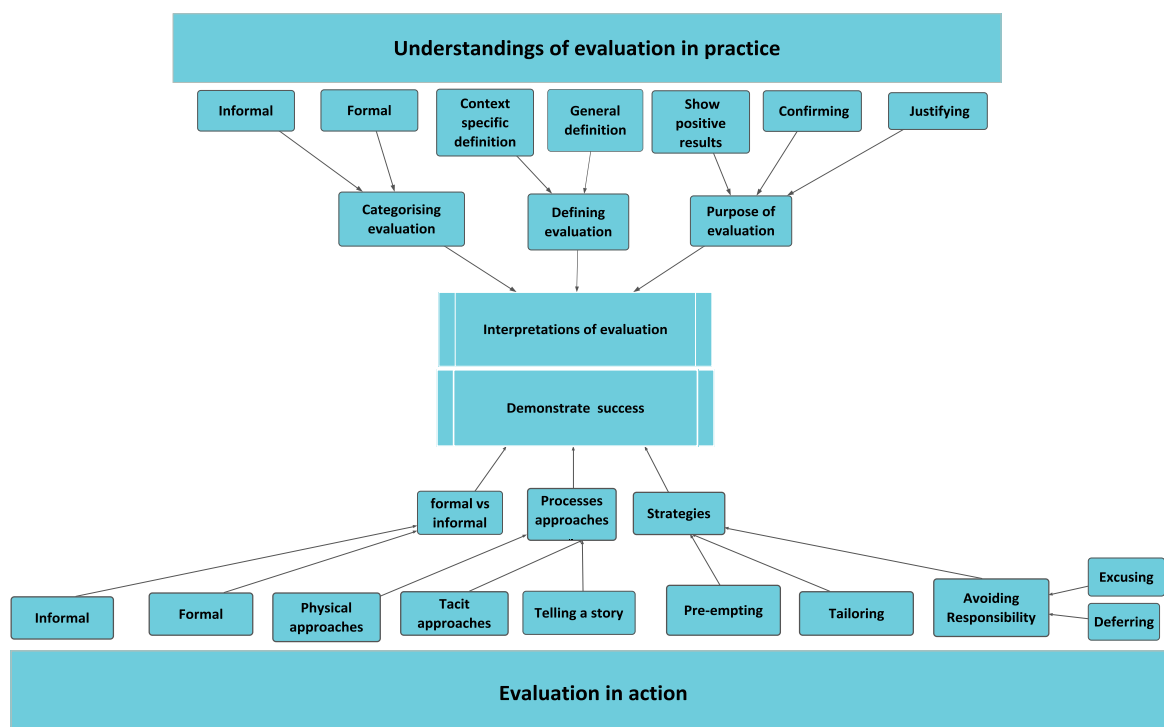
This methods chapter has provided a detailed description of the methodological choice and specific data collection approaches used to answer the research question. The research design and qualitative methods were used because they were ones that would allow the researcher to use a mixture of methods to collect rich in-depth data and present the 'native' or 'insider view' (Labaree 2002). In addition these approaches used will enable the researcher to produce empirical data to contribute to the understanding of how evaluation is perceived and conducted by staff in a service environment.

## Section Two: Study Findings

The aim of the study was to find out how evaluation is perceived and carried out by public health and health professionals working in a primary care setting, and each of the results chapters in this section focuses on particular aspects of evaluation in practice. The findings of the study are presented in four chapters in this section. Chapters four and five, provides an understanding of the context in which the participants were working. This included examining documents that participant had accessed to gain an understanding how evaluation was represented in national and local policy and guidance documents. These chapters provide insights into the contextual factors that were found to influence how evaluation is perceived and how it is conducted in practice. They are primarily descriptive.

Chapters six and seven present the themes that emerged from the initial analysis of interview and observation data. In these chapters that themes that illustrate how the participants perceived and understood evaluation and how it was being carried out in practice are presented in figure 6.

**Figure 6: Findings: Thematic framework.**



## Chapter Four

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### **4 An understanding of evaluation from the documents available to participants**

#### **4.1 Introduction**

In this chapter, the findings from the documentary analysis are presented. It was from this analysis of the documents that the difference in the way evaluation is referred to and represented became clear. Differences were found between what was presented in national and local documents concerning the way that evaluation was defined and referred to, and the type of instruction given to guide the evaluation process.

The Health Check programme, like other national health programmes, was accompanied by a series of national and local policy and guidance documents designed to inform and support the implementation and delivery of the programme. It was therefore considered relevant to explore the content of the documents and written materials available to those responsible for local evaluation activities in this study. The content of these documents were analysed in order to understand the extent to which evaluation was being addressed in the guidance. Firstly, an overview of the documents that were available to study participants will be described, followed by an analysis of the content of the documents to understand how evaluation was represented in these documents.

#### **4.2 The documents available to the participants**

The analysis of the documents available to those involved in implementing and delivering the Health Check programme showed that a variety of evaluation methods were represented in the different type of documents. The documents and materials found were categorised into three groups according to their origin and their relevance to the implementation of the Health Check programme. The documents found were categorised according to the organisations they had originated from. The documents from organisations such as NICE, the MRC and Faculty of Public Health (FPH) were categorised as generic documents. They were generic as they were not associated with a specific programme but referred to the evaluation of public health programmes

in general. The documents that were specific to the Health Check programme and developed by Department of Health (DH) the National Health Service (NHS) and Primary Care Trusts (PCT) were categorised as programme-specific local and national guidance documents.

All documents examined as part of the documentary analysis were stored in the SharePoint drive. The SharePoint drive was a file storage web based system where all the documents relating to the implementation of the programme were uploaded and stored by the core members of the task group. This drive was maintained by PHM3, who uploaded documents on the drive and used it as a central place to store the Health Check programmes policy documents, meeting agendas and minutes, and any other documents that were sent to her from the national team.

PHL1 and PM3 referred frequently to the following guidance documents that were found on the drive; 'The vascular disease handbook' and 'Best Steps: the DH's best practice guidance'. Study participants explained that it was these documents that were used to inform the implementation of the Health Check programme. PM3 in particular said that this was what she used to ensure that she got all the elements of the programme correct.

On examination of these documents, references to evaluation were limited. There was only one reference to evaluation found in the DH best practice guidance document. In this one reference, it was stated that an evaluation of the programme was necessary, but there was no supporting information describing what form the evaluation should take, or what was required.

#### **4.3 Generic guidance documents**

The documents that have been categorised as generic are the ones that were developed by organisations external to the NHS, and were not ones that were specific to the Health Check programme. Both organisations and their documents were referred to in interviews. The task group members also referred to the generic NICE guidance mentioned in the Health Check handbook that was produced by the task group, suggesting that the NICE guidance was regarded as particularly relevant and useful.

In the NICE and MRC guidance documents evaluation was defined as something that demonstrated the effectiveness or impact of a programme. The process was described as structured and systematic. In the NICE document, evaluation was defined in broad terms:



‘Evaluation, on the other hand, is the formal assessment of the process and impact of a programme or intervention’ (NICE 2007: p 18)

In the NICE document, evaluation was therefore described not only as a process that provided evidence of a programme's impact but also one that assessed the process. In an MRC document the description was more constrained, and evaluation was described as a process that should aim to produce empirical information that is analytical in nature and could be used to support judgements regarding the effectiveness of a programme.

Developing, piloting, evaluating, reporting and implementing a complex intervention can be a lengthy process. All of the stages are important (MRC 2008: p 4).

#### **4.3.1 National programme specific documents**

The generic guidance documents portrayed evaluation as a structured and systematic research process. The focus was on interpretation and analysis of data to provide objective information or evidence to demonstrate the effectiveness and effect of a programme:

Evaluations of complex interventions should be reported whether or not the intervention was 'successful' and in a way that enables the intervention to be reproduced or adapted for the purposes of further research or for larger scale implementation. (MRC 2008: p 11)

In the Primary Care Service Commissioning Framework for Vascular Checks, a programme specific document produced by the national Primary Care Commissioning team to support the commissioning of services, evaluation is described as a service related activity. A number of participants referred to this guidance document as the one they used to develop a business case to secure funding for the programme. PM4 and PHL1 explained further that this document was what they used to support the development of the service specifications to commission the delivery of programme.

Service providers will need to demonstrate the effectiveness of the service to commissioners possibly at regular times during the year and, at the very least, on an annual basis. This will need to be provided to the commissioners in an annual report, which will inform any annual review process or meeting. (This information will also help commissioners in planning any other related services required.) The process by which this evaluation is achieved can also be

used to show the outcomes of the service to other key stakeholders such as people and family carers (NHS Commissioning Framework 2008; p 3)

Of all the national programme documents provided by members of the CVD group relating to the implementation of the programme, the NHS Commissioning Framework contained the most instructions regarding evaluation. However, evaluation in this document was referred to as a "service evaluation" and an emphasis was placed on the collection of data to monitor performance and to measure service activity. Evaluation was also described as the process that would provide those paying for the service with information about the effectiveness of the programme. It set out both what data needed to be collected, and why it was required.

Additional key documents described were ones that members of the core group mentioned during the interviews and conversations. They were: 'The Vascular Disease Handbook' and the DH's best practice guidance documents, 'Best Steps'. In these documents, references to evaluation were also limited. One reference to evaluation was found in the Department of Health Best Practice guidance document, and this was in relation to evaluation of the programme being necessary, but there was no further information to support this statement or describe how evaluation could be done.

#### **4.3.2 Local policy and guidance documents.**

At a local level, a number of policy and guidance documents were developed by different groups within the PCT to support the delivery of the programme. However, the distinction between monitoring and evaluation, made explicit by the MRC guidance, was not reflected in the documents produced by the team in the Primary Care Trust (PCT). In these documents, the processes and activities listed as monitoring and evaluation focused on the routine collection of data. Evaluation was described as a process that was associated with monitoring service activity. Under the heading of "evaluation and monitoring" these documents gave a detailed list of what data should be collected and how the data collected should be used.

An additional key local document was the report of the review of a pilot of the Health Check programme, which was done before the programme was fully implemented by the PCT. This report was prepared by those who were involved in the initial implementation of the programme. It appeared to serve two purposes, one to provide a description of the procedures

required for the delivery of the different elements of the programme, and the other was to outline what type of data needed to be collected and which systems were needed to monitor the programme. There was one reference to evaluation in this document, which was found in the appendix, in the healthcare assistant's job description. The healthcare assistant was to be employed to carry out the Health Check assessment in the doctor's surgery and to support any evaluation processes (Roles and responsibility in job description for programme staff, Grade 4 post).

#### **4.4 Nature of the instructions relating to evaluation**

The generic guidance documents portrayed evaluation as a structured and systematic research process. The focus was on interpretation and analysis of data to provide objective information or evidence to demonstrate the effectiveness and effect of a programme:

On the other hand, in the documents produced by the DH, evaluation was in fact described as monitoring. The focus was on monitoring the delivery of the programme, and its ongoing performance and activities.

In the local PCT guidance, there was a detailed description of what forms of data needed to be collected. It was clear that the origins of a document and its purpose determined how evaluation was defined and described as a process.

In the NICE and MRC generic guidance, evaluation was described as a form of research with clearly set out guidance on how the process should be carried out and how findings should be reported. The documents developed by and for the PCT on the other hand describe evaluation in terms of a process to gather data. The local documents advise that robust data collection systems should be in place to monitor performance and effectiveness of a programme. What was important was being able to show that the programme was successful. However, what this means for the programme's potential impact, or how these results can be demonstrated, was not explained in the documents.

Instructions in the generic guidance documents relating to evaluation in general tended to be more explicit. The instructions in these documents were more directive in nature about how evaluation should be carried out. Details of the approaches and methods that should be used were included however they focused on the use of research approaches. In the MRC guidance,

for example, there was detail on how an evaluation report should be structured and what it should include.

“If a conventional individually-randomised parallel group design is not appropriate, there are a number of other experimental designs that should be considered” (MRC: p 10)

However, this guidance was described in the context of what processes to look for when having to make a judgement of the robustness of an evaluation. In other words, it clearly described what to consider when assessing if an evaluation was done properly and the necessary requirements for an evaluation to be judged as robust.

While the instructions in both the MRC and NICE documents clearly state that an evaluation must be part of the programme’s implementation, there was no specific mention of procedures that should be in place to enable a robust evaluation to happen. The one reference to evaluation in the DH Best Practice document was regarding the information that was available to help PCTs assess the impact of their programmes.

In comparison, the instructions in the programme in specific documents by the national team, such as the ones for the Health Check programme, were less directive and the need for evaluation largely implicit. References to evaluation in these documents were not accompanied with specific instructions, but were merely in the form of suggestions. References that were made regarding evaluation in the local documents focused on what data needed to be collected.

“It is important to identify a minimum dataset which is agreed nationally and to develop MIQUEST queries so that meaningful evaluations can be undertaken to inform the commissioning of the programme” (PCT Health Check Handbook 2009: p 5)

It was unclear in both the generic and the programme specific guidance documents how and when an evaluation of a programme should be done. There were no instructions provided to guide the evaluation process in the documents reviewed, nor was there a specific mention of procedures that should be in place to enable a robust evaluation to happen.

## 4.5 Summary

In all the documents, regardless of their origins, evaluation was stated as being an integral aspect of the programme planning and implementation process. The origin of the document did determine how evaluation was defined and how it suggested evaluation should be carried out. The documents produced by organisations external to the NHS, such as NICE and MRC, defined evaluation as a way of assessing the impact and effectiveness of a programme. An emphasis was placed on the use of scientific research approaches to generate empirical evidence. The outcome of evaluations as described in the MRC and NICE documents were to provide evidence that was objective and can be used to judge the effectiveness of the programme for the population or for those who will be receiving an intervention.

In contrast, the definition of evaluation in the PCT documents indicated the importance of being able to show that the programme is successful, but what this means or how it can be demonstrated was not explained in any detail. The document analysis showed overall that there was not only a difference in the how evaluation was defined as a process but also the level and type of instructions that were provided. There was little information found about the practicalities of how evaluation should be carried out in any of the available documents.

## Chapter Five

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### 5 Understanding the setting

#### 5.1 Introduction

The findings in chapter five gave an outline of the contextual structures and arrangements that were in place to support the delivery of the Health Check programme. The findings in this chapter also provide an insight into the context in which the participants were working and carrying out with their day-to-day activities and the factors that influenced not only how evaluation was perceived, but participants' views on how they would conduct evaluation.

After working alongside participants and reviewing national and local programme documents, a clearer understanding of the structures and arrangements relating to the implementation and delivery of the Health Check programme emerged. This was invaluable in exploring how evaluation, both as a concept and as an activity, was influenced by the context in which it was being carried out.

This aim of this results chapter is to provide an understanding of the context in which the participants were working. The description of organisational structures and arrangements provide a deeper understanding of the context in which the participants were working to deliver the Health Check programme. The structures and arrangements relating to the implementation of the Health Check programme were ones that were in place before April 2013. They are based on descriptions from the participants as well as the researcher's findings whilst in the field as a participant observer. The participants' roles and activities within the organisations concerned with the Health Check programme are also described, in order to illustrate the importance of relationships among the organisation and groups involved that were involved in delivery and management of the Health Check programme.

## **5.2 The organisations, groups and individuals involved in delivering the Health Check programme**

The researcher was familiar with the PCT and the Public Health Directorate in which the fieldwork was conducted as she had worked there in the past as a public health specialist before leaving to study. The researcher did have an understanding of the overall structure of the PCT, as well as of the specific organisations within the wider health service environment. However, she was not familiar with the specific arrangements and structures that were in place for the management and delivery of the Health Check programme.

Figure 5 provides a visual depiction of the organisations and groups that were in place during the fieldwork period of September 2011 to March 2013. Based on interviews with participants and observations at meetings, the researcher mapped a total of 18 different groups and organisations in place at the national, regional and local levels managing and delivering the programme.

**Figure 7: Organisation and groups**

**The organisations and groups involved in the implementation,  
delivery management of the Health Check programme**

**Organisations and teams at national level**

National Policy  
team

Information National  
team

Department of  
Health

Diabetes and Kidney  
National team

**The organisations groups and teams at regional level**

Strategic Health  
Authority (SHA)

Regional Health  
Check Group

Performance  
Management team

**The organisations groups and teams at local level**

Public Health  
Directorate

Health  
Improvement Team

Clinical  
Commissioning  
groups CCG

General Practice  
GP

The Primary  
Care Trust  
PCT

Lifestyle Service  
provider teams

The Local Authority

Health Informatics  
team

Commissioning  
Directorate

Pharmacies

Software Companies

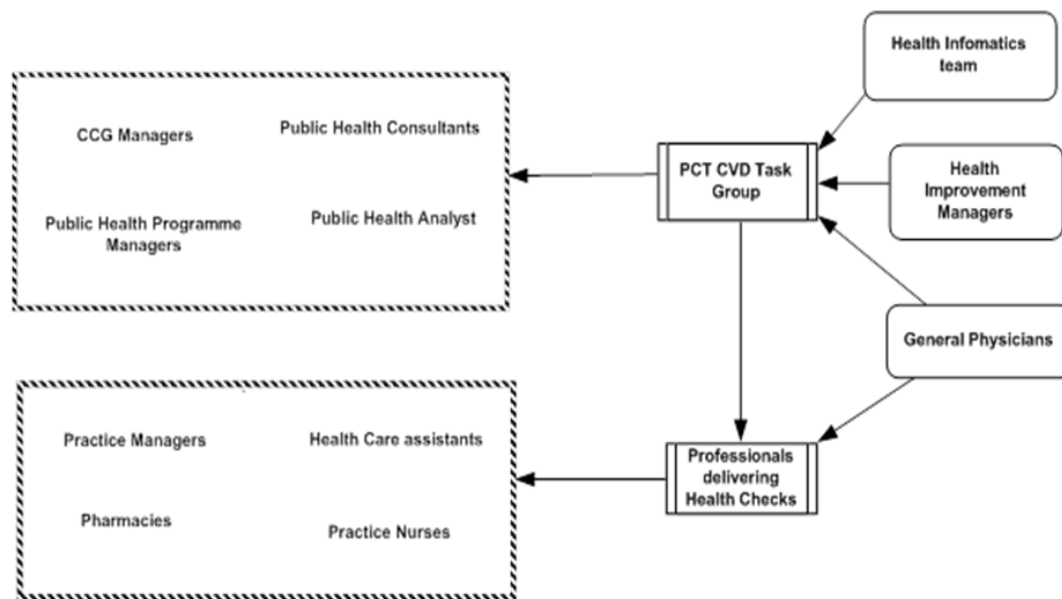


At the national level, there was the Department of Health (DH) and a number of national teams that were responsible for developing the policies and guidance to support the implementation and delivery of the Health Check programme. The Strategic Health Authority (SHA) was the regional NHS organisations had regional oversight of the performance implemented locally. There was also a public health team in the SHA that was involved in the monitoring of the Health Check programme. This team included Public Health consultants and Regional Programme managers. They determined the regional targets and reporting arrangements for the programmes in the area and liaised with the local primary care trust (PCT) teams and the DH national team.

At the local level, the Primary Care Trust was the organisation responsible for implementing, managing and ensuring the delivery of the Health Check programme. The public health directorate had the remit to commission and implement the programme at the local level. Other directorates were involved, such as clinical commissioning and health informatics, which provided support to the public health team when required. Public health professionals within the public health directorate were responsible for commissioning, implementing, managing the delivery and monitoring the performance of the programme. Elements of the programme were delivered by individuals working and employed by General Practitioners (GPs). The GP surgeries were commissioned by the public health team to deliver the programme. Contractually, GPs were the providers of the programme, and their staff were expected to identify and invite individuals, and to do the Health Check assessment. The GPs were expected to provide the necessary treatment, advice and referrals to lifestyle programmes, such as smoking cessation services and weight management programmes.

As well as commissioning the GP surgeries to provide the programme's services, the public health team also commissioned a software company that provided the necessary software for the programme to enable GPs to identify and invite individuals for their Health Check assessment. In return, the GP practices were to provide routine data to the public health team to enable them to monitor the programme activities. This routine data included how many people were invited and how many people were attending for Health Check assessments.

**Figure 8: Groups and individuals involved at local level to deliver the Health Check programme**



Two groups were in place to support and manage the implementation and delivery of the Health Check programme, a group within the PCT (the CVD Health Check group) and the regional group. The PCT's CVD group was attended by individuals from a number of different directorates. This CVD task group were responsible for commissioning and overseeing the planning, implementing and monitoring the Health Check programme for the PCT. In addition, members of this group monitored the performance of GP surgeries who were delivering the programme. The members of the CVD task group were from three of the PCT's directorates: Commissioning, Health Informatics and Public Health. Also part of the group were Public Health consultants, Public Health specialists, Senior Public Health and Health Improvement managers, a senior Public Health analyst, Senior Health informatics manager and senior managers from the commissioning directorate. The regional Health Check group was attended by the programme managers and public health consultants from all the PCTs in the region. This group monitored performance on a regional level to meet national, regional and local targets set for the programme. The relationships between the groups and individuals delivering the programmes are illustrated in Figure 6.

### **5.2.1 The public health workforce skills and capabilities**

Insight into the participants' professional status and their roles and responsibilities within the PCT, as well as their professional knowledge and skills in relation to evaluation, provided an understanding of the participants' capabilities in relation to their status in the organisation concerning their capacity to initiate and conduct evaluation. Capabilities in this context include not only experience and training in evaluation, but also their professional status and autonomy within the organisation. In particular, the participants' power to instigate and evaluate the programmes they are implementing was considered to be important.

The participants involved in the delivery of the NHS Health Check programme were a mixture of professional backgrounds and professional grades. Staff within the NHS are employed in one of nine pay bands, and these bands reflect the knowledge, responsibility, skills and effort needed for the job. According to participants, their levels of responsibility and autonomy increased according to their pay bands, as did expectations about their responsibility to evaluate the programme.

Staff in bands 8 and 9, for example, would have the relevant skills and knowledge, as well as the autonomy to lead and be responsible for evaluating the programmes they involved in delivering. Public Health consultants are employed at bands 8 and 9 and as such are considered senior members of the workforce with the autonomy and authority to initiate and carry out evaluation. This was acknowledged in their interviews. In addition to operating at a senior level in the NHS, staff in bands 8 and 9 were also members of the Faculty of Public Health, a professional body membership. This would imply that these staff members had the required expertise to play an instrumental role in evaluating public health programmes.

The participants who were senior managers were employed at a senior enough level also have the relevant skills and the autonomy to instigate an evaluation. While they acknowledged that they had the skills, they did not feel that they necessarily had the right experience required. They noted that they could evaluate the programme with support from more experienced members of the teams.

### **5.3 The activities of the groups and individuals involved in delivering the Health Check programme**

It was observed that three individuals within the public health directorate carried out the day-to-day management of the Health Check program. Participant PHL1, a public health consultant, was the PCT designated lead for the Health Check programme, who had the strategic and operational responsibilities for the programme. He was a public health consultant who had been working on the programme for three years and had taken over the management of the programme from public health lead PHL2 and public health consultant PHL3. He was responsible for monitoring the programme's performance, ensuring that national standards, service specifications and targets for the programme were met and achieved. He chaired the PCT's CVD task group monthly meeting as well as the Regional Health Check group bi-monthly meetings. In addition to the Health Check programme, he was also the lead consultant for a number of other public health programmes that were related to cardiovascular diseases. He oversaw the activities of the manager PM3 and liaised with the PM4 the public health analyst.

The second participant responsible for day-to-day management was the programme manager, PM3, who was employed to manage the delivery of the Health Check programme. She was instrumental in ensuring that the programme's activities were planned, implemented and managed. The Health Check programme was her only responsibility.

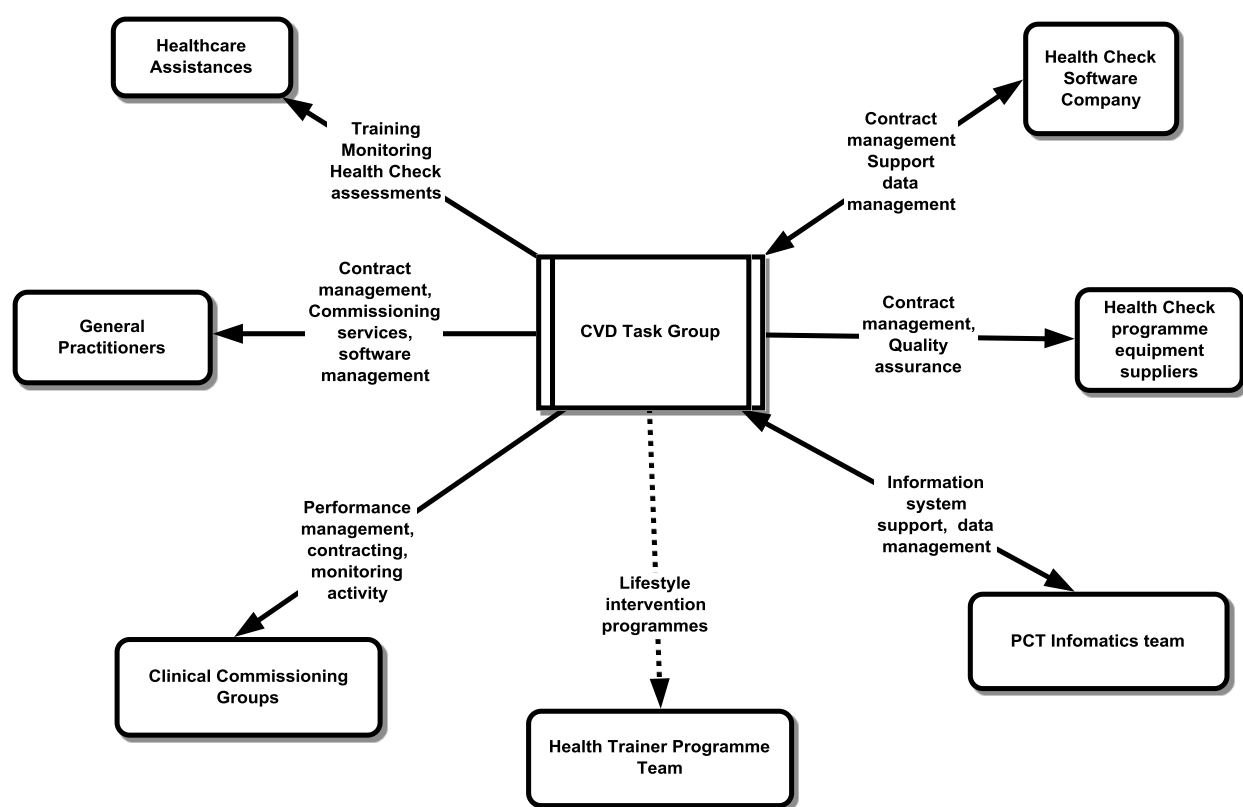
The other person who was essential to the implementation of the programme was PHM4, a senior public health analyst. PHM4's role was to set up the systems to collect the data, gather the programme activity and monitoring data, and produce the data reports that were reviewed at the CVD task group's meetings.

These participants formed the core group because they were the individuals that were observed to be actively involved in the day-to-day operational aspects of delivering the programme. They also were involved in making operational decisions about the programme and setting the strategic direction for the implementation of the programme.

Other participants were members of the CVD task group but were not involved in the day-to-day management of the programme. The generic roles and responsibility of their posts, and the directorate that they were based within, determined their level of involvement. The Health Check programme formed only one aspect of their overall remit and therefore most of their interaction with the core team was passive. They tended to wait until they were specifically asked

to contribute to the programme in some way by the core team. Participants CM1, CM2 and CM4 were senior managers from the commissioning directorate. They were responsible for the overseeing the commissioning aspect of the programme and they represented the newly formed Clinical Commissioning Groups (CCGs). Other individuals in the PCT who provided support to the core team were two public health consultants, participants PHL2 and PHL3, who were involved in the initial planning and implementation of the programme but no longer had an active role in the management of the program. They continued to be kept informed of the programme's progress. The other members of the task group were the public health managers involved in associated health improvement programmes that were linked to the Health Check programme activities. PM1, PM2, and PM7 and were members of the PCT CVD group. Figure 7 shows the structure of this group.

Figure 9: PCT CVD Task Group



The PCT began the roll out of the programme when the national rollout began in 2009, and had decided to implement the Health Check programme as a screening programme to be delivered by GP practices.

The group, chaired by PHL1, met every month to review the programme activity, discuss the programme progress and delivery. The researcher attended six of the task group's monthly meetings during the data collection period and observed that the numbers of people attending the meetings varied. At one meeting, for example, participants PHL1 and PHM3 and the researcher were the only attendees. PHL1 explained that not all of the 20 individuals on the circulation list regularly attended the monthly meetings. Some people were no longer actively involved in the programme, but were still on the list, as he liked to keep them informed of the programme's progress and performance. PHL1 explained that attendance depended on what was being discussed. If specific issues needed to be resolved then someone from the relevant directorate or group would be specially invited to attend the meeting. Attendance at the meetings and contributions to the functions of the group were determined by PHL1 and PM3. They tended to invite or ask people to attend based on the current requirements of the programme and the needs of the group.

The Health Check regional group had a representative from each of the PCTs in the region. The regional group, also chaired by PHL1, met every two months to assess progress in the region. The group met to review the programme data and share information about their programmes. It was at these meetings that teams from the other PCTs had an opportunity to discuss problems they were having with the implementation of the programme and to ask for suggestions to help solve problems they were having. This group collectively made decisions about how best to address changes in policy, and about what would be communicated to the national team. It was explained by PHL1 and RM1 that it was at a meeting of this group that a decision was made to commission a software company to provide software that all the programmes in the region would use. The reason to do this, they explained, was to ensure that there was a standardised approach to data collection.

*"We're lucky in our area because we've been trying to do things systematically as it's been going along so I think we are the only area I'm aware of that has a formal group that's been in place for a long time, we're also the only area that has a proper IT support behind the programme so we actually have data available" (PHRM1).*

One of the regional managers, participant PHRM1, maintained regular contact with the local programmes and was responsible for reviewing activity data and performance of PCTs implementing the programme. PHRM1 was the person within the SHA who communicated regularly with the local programme groups, getting feedback about the progress and performance of the Health Check programme. She was the person, she explained, who had to report back to the national team about the performance of the programmes in the region. Her role was to understand what was happening within the programme and to take the necessary steps to support the programme teams to meet their targets. She also explained that SHA, as an organisation, did not have any financial or statutory powers to act as leverage to ensure that those implementing the programme did what was expected. All she could do was to ensure that teams at local level had the capabilities to deliver the programme to the national requirements and standards.

Other non-PCT organisations that were involved primarily in delivery aspects of the programme included GP surgeries, the Software Company that provided the programme's software, local organisations (such as pharmacies and local authority services providing lifestyle programmes), and private companies that provided the equipment required for the programme.

### **5.3.1 The remit of the Senior Manager**

To illustrate the practicalities of implementing and delivering the Health Check programme, the activities of the senior manager of the CVD task group are described. The aim of this detailed description is to provide a picture of what happens in practice and to give some insights about the practicalities of conducting evaluation at a local level.

PHM3 was the only full-time person in the PCT employed to manage the implementation and delivery of the health check programme. She described her range of day-to-day activities as managing and monitoring the performance of those who provide the services that enable the Health Check programme to be delivered. She used the words “keeping an eye on things” to describe these activities. This role involved strategic planning, setting up systems and responding to problems the GP practices were having with the software and data. She spent significant amounts of time managing the programme data and preparing letters about the programme. She personally made sure that information for the programme was submitted by the practices so that the monthly reports could be prepared and sent to the SHA. She developed the training

programme and delivered it to the health care assistants who were doing the Health Check assessments in the practices. Her role, as she explained it, was to make sure the programme was being delivered and that it was meeting the national standards.

*"... we've done it by making sure the practices have that guidance, know what the health check is, delivering training programmes so all the health checks should be delivered to a certain standard in the same manner" (PHM3).*

It was observed that her activities included a long list of operational activities, such as preparing service specifications, ordering, and disseminating nationally developed programme material to all those implementing the programme. She took on the responsibility of ensuring the programme software was set up and working on GPs' systems. She also prepared service contracts and service specifications, and managed the programme's budget. She produced and regularly updated the handbook for the programme. The Public Health consultant and Public Health analyst gave her support when this was required, but she was the person who was making the decisions about the programme and its progress.

In addition to the programme management and monitoring activities, she was also observed to be supporting the professionals who were delivering the programme in the GP practices. She liaised with members of the national and regional teams and the other programme managers in the region, and shared information to keep up-to-date with policy changes and changes in monitoring requirements. A large amount of her time was spent responding to phone calls about the software and problems people were having with entering and uploading the data. She explained that GP practice surgeries received payment for the number of Health Checks they had done and so she liked to make sure that the information provided by the practices was correct. This was not a straightforward process, she explained, as data from the practices did not always match the data she received from the software company, and she had to be able to rely on information provided by the GP. The answer to this problem was for her to establish her own database to populate in order to be assured that the data she was receiving was correct.

She tried to visit all practices in the area taking part in the programme once in the year to make sure that everything was working satisfactorily. Her visits, she said, gave practice managers at the surgeries the opportunity to ask questions and to give feedback about the programme. This



way she could ensure that practices knew what they were doing and had no excuse not to provide the right data at the end of each month.

It was also observed that the senior manager and the other members of the core group did not often physically meet outside of the monthly meetings. Instead, most of their discussions were done via the phone. The few times that she did meet with PHL1, their conversations focused either on a particular problem relating to the delivery of the programme or on gaining assurance that she was making the right decisions in relation to implementation of the programme. However, when they met, conversations were more about exploring strategies that could be used to engage the practices that were not delivering the programme. She explained that there were a number of practices that were refusing to offer Health Checks to their patients. In her opinion, this had the potential for patients being deprived of a service that they were entitled to. The other concern was about the impact this would have on the programme's performance figures, preventing the team from being able to meet the annual national target.

She spent a significant amount of her time talking with practice managers, giving them support and advice about the programme and preparing and updating all the programme material. She explained that with all that she had to do to get things in place, she had little time to devote to planning and ensuring that an evaluation of the programme was carried out. She explained that she did know that a programme manager for one of the other programmes had done an evaluation, but she had not had a chance to review the report.

### **5.3.2 My activities as an active participant**

By the time the researcher became a member of the group, most of the managerial and operational processes were already established and in place. During her time in the PCT, the researcher worked alongside PHM3, helping her with administrative tasks and generally commenting on information that was provided by the practices. At the start, the researcher was given general administrative tasks, such as preparing the monthly letters to be sent to GP practices and preparing the programme handbook ready for distribution.

The researcher was also given some other specific tasks, one of which was to update PHM3's local monitoring and performance management systems which she had developed for her local use. She explained that over the years she had developed and put in place a number of

spreadsheets and databases that she used to keep track of different operational aspects of the programme. With her own systems in place, she could effectively monitor the programme activity data. She explained that this enabled her to evaluate if the figures being reported were accurate. Although these spreadsheets were additional to the programme monitoring data that was generated by the software company, she explained she liked to have her own data. However, the changing context of the programme was making it difficult to keep her systems up to date, as GP surgeries were continually merging, changing partnerships and closing. Each time a GP practice merged or changed, she had to update her information to ensure that everything remained accurate and linked.

In addition, due to the recent changes in reporting requirements, she had to provide monthly reports to SHA, set up and run the training sessions for the health care assistants, and respond to practice managers' queries. Not surprisingly, she was finding it difficult to update and check the spreadsheets. The researcher was therefore given the task to check and update the spreadsheets and databases. They contained a range of detailed and comprehensive data on the programme activity. When asked what she was planning to do with all the data she had locally, the PHM3 explained that sometime in the future, it could be used to evaluate the programme, but for now, it was just waiting to be used. Her priority was simply to get all the systems in place, in order to be able to collect the data.

The researcher in her capacity as a public health specialist with training in research and evaluation methods was asked by PHRM1 to contribute to the development of a regional evaluation of the programme. This was something the PHRM1 had been considering doing for some time, but was waiting for sufficient programme data to be collected. She also wanted to wait until the PCT had their programmes up and running across the region. She asked the researcher to give advice regarding how best to use the data that had been collected and to help identify the best way to approach doing a regional evaluation of the Health Check programme. After a number of meetings with PHRM1 and with the members of the regional group, it was decided that a proposal for a regional evaluation of the Health Check programme should be developed. It was decided that it should be a service evaluation as the main purpose would be to gain a better understanding of what was needed in order to improve the delivery of the programme. In particular, the evaluation would support a better understanding of the uptake of the Health Check programme across the region, which would enable identification of low uptake PCTs and practice populations. PHRM1 and PHL1 saw the evaluation as an opportunity to get an overview of how different PCTs in the region were going about delivering the programme. The

researcher was given the task to examine the available data and to explore what other forms of data could be obtained in order to enable an evaluation of the programme to take place.

#### **5.4 The nature of the arrangements and relationships between the participants and organisations**

The participants described their relationships within the organisation according to their functions and associated activities. There was a general view amongst all of the participants that the level of communications between local and national teams was poor. This lack of communication between the national team and local teams was reflected in the difficulties in establishing which group or team at the national level was ultimately responsible for the Health Check programme. This made it difficult to determine how the impact of the programme was going to be assessed. The researcher established which teams in the DH were responsible for the Health Check programme from the national programme website as the participants were unclear themselves who were the key individuals.

In addition, it was a constant challenge for relationships to be established, as the membership of the national teams involved in the programme often changed. The researcher attended three national learning workshops during the year, and at two of the workshops new people were introduced as part of the national team involved in the programme. These changes, PHL1 and PHM4 admitted, did make it difficult to identify who was responsible for the programme at national level and who should be contacted when some clarity was needed regarding the implementation of the programme. This level of information was rarely communicated to the local teams.

At the national level, there were a number of national teams within DH providing guidance to support programme implementation. These teams were viewed by participants as being non-operational, dedicated to developing policy, setting and providing the strategic direction and national steer. Importantly they were perceived by participant as the teams that devised and set the programme targets.

The relationship between the local teams and the national teams was observed to be distant. The nature of this relationship between the national and local teams was reflected in the accounts provided by PHL1, PHL2 and PHRM. The national team did not provide that appropriate

policy direction and operational support required to support the implementation and evaluation of the programme.

*"so because this programme was launched and it was the Department of Health said, you know, 'start the programme and really how you deliver it is up to you to decide" (PHL2)*

The delivery of the programme was left to "local determination" or, as participants explained, they were told to get on with delivering the programme. This local determination also extended to evaluating the programme, which meant that there were divergent views about what was required in relation to the evaluation of the programme. The researcher learned from the conversations at the national meetings, and from the participants, that different approaches to commissioning and delivering the programme were taken by PCTs. This, according to the participants, meant there would be little consistency or standardisation of the approaches used to deliver the programme across the country. They all agreed that the lack of a standardised approach was an issue for carrying out evaluation, because there would be no ability to compare results with other programmes.

The local decision to base the programme's delivery on the principles of a screening programme indicated that, at the local level, professionals did have some level of autonomy to decide how to deliver the programme. PHL1 felt it was necessary to take a systematic approach to implementing and delivering the programme, and to facilitating future evaluation. This was, in fact, provided as the rationale for modelling the programme as a screening programme.

The majority of GP surgeries in the area had agreed to deliver the programme. This was seen as a very positive achievement, as the programme would be able to meet some of its targets. However, there was a perceived pressure to ensure that the few GP practices that had not initially taken part in the programme agreed to participate.

## **5.5 Resources provided to implement and evaluate the Health Check programme**

There was a consensus that the necessary frameworks and resources required to support the evaluation of the Health Check programme were lacking. Participants expressed an

expectation that DH would provide the support to enable an evaluation of the Health Check programme. In all the interviews, participants referred to the lack of support from DH, in the form of tools, frameworks and financial resources. Participants did not feel that they were provided with any clear instructions or a framework to support them to carry out an evaluation:

*"...there was no national steer on a lot of it and a lot of it was 'well see how you go this is the basic' they give us a blue book from Leicester Uni and it was 'this is the outline and then off you go'(PHL2).*

The national and local guidance documents produced did set out what procedures and processes needed to be in place, so that specific elements of the programme met national standards. This included guidance on what appropriate advice, treatment and lifestyle services should be provided to ensure that the programme could meet its objectives. This included the specifics of referring patients to smoking cessation, weight management and exercise services.

*"I did go to the first half dozen national meetings and the overall feeling all those meetings was they were just trying to work out how we were doing this because all the documents came out after our meetings so they weren't meetings to share the documents with us, they were meetings to provide the information to go into documents. And it was about 'oh what problems are you having?' and so the documents were there to sort of put some things right in some respect"(PHL2).*

There was awareness that there were frameworks and guidance available to support and guide an evaluation process. The range of material and resources identified by participants as being necessary to enable them to evaluate programmes included both the generic and programme specific frameworks and tools kits produced by national and funding organisations. However, the participants felt that they would benefit more from the experienced and skilled individuals and teams within the PCT. They were actually identified being an essential resource for carrying out an evaluation. Participants explained they tended to seek the support and advice from colleagues within the organisations, rather than use the guidance documents. The support

provided by colleagues was described by one participant as much more useful and helpful than information provided by the funding organisations.

*"....I spoke to somebody who had evaluated a project and they were very very helpful ...basically to took me through, right, this is like you have a cover page and took me through step-by-step ...was very helpful actually because it is something now that I feel that I do" (PHM1)*

This reliance on colleagues or other professionals in the organisation was evident when the researcher was approached by two of the participants. On separate occasions the researcher was approached to provide advice about how to go about evaluating a programme they were in the process of implementing. The reason they gave for approaching the researcher, when asked, was that they knew the researcher had experience in evaluating programmes, and they felt more comfortable in approaching someone they knew for advice. This was also reflected in other examples participants gave regarding seeking advice, in which they explained they would go to someone they knew for advice rather than use the generic or programme specific frameworks. PHM6, for example, explained she got advice from one of the public health consultants, who according to her had the knowledge and experience of evaluating programmes. PHM1 explained that she asked someone she knew in the research department for help and advice. It was observed that the Public Health directorate was well staffed with a mixture of specialist and non-specialist public health managers, consultants, health improvement managers and public health specialists. The PCT also had a research department and health informatics department that provided public health analytical support to the public health team.

At the same time, participants were fully aware of where to find examples of evaluations that they could use to support and guide the development of an evaluation process. Participants gave examples of guidance documents, published evaluations of programmes, frameworks, and tool kits and confirmed that they were aware that these provided models of good practice in relation to evaluation. They also viewed national guidance produced by agencies such as NICE as providing a valid framework for evaluation. One of the commissioning managers explained he regularly referred to guidance produced by NICE. These accounts did indicate that participants were aware of what was available in terms of information that could be used to support the evaluation process.

*"I have to say I think that's what NICE tries to do is those NICE evaluations seem to be like models of good practice where they're taking big areas looking at best possible expertise getting best practice and giving you I think that's been a very helpful, that's a very helpful evaluatory framework". (CM4)*

Participants expressed that they had expected the DH to provide the steer for the evaluation of the programme or provide a framework that they could use to evaluate the programme. There was an expectation that national teams would develop and provide the programme with appropriate policy and guidance documents to support the local evaluation and provide appropriate guidance to provide a standardised data collection template to assist a national evaluation of the programme. At each of the national meetings attended, questions about evaluating the programme were asked by those attending the meeting. In response to these questions, the members of the national team encouraged those involved in delivering the programme to evaluate the programmes locally and share their findings with other programmes. The view amongst participants was that the different modes of delivery used by PCTs across the country would make it very difficult for a national evaluation to be carried out. It was also pointed out at these meetings that economic modelling of the programme had been done and this was a key form of evidence for the programme that could be used to support future evaluations of the programme.

## **5.6 Summary**

A number of contextual factors were identified as important determinants of how evaluation was defined, perceived and conducted, including the complex and overlapping organisational roles and responsibilities, and sources of support (or lack of support for local evaluation and the constraints on local evaluation).

In total, 18 organisations were involved in planning, implementation and delivery of the Health Check programme. Each of the organisations and groups had their own set of conditions and expectations that needed to be fulfilled, as well as a range of monitoring standards and targets to achieve. This does not include nearly a hundred individual GP surgeries and their practice managers that the members of the CVD task group also interacted with to deliver the

programme locally. The participants who were members of the CVD task group engaged with large numbers of organisations, groups and professionals. It was apparent that the members of the task group had to consider these and to adapt their actions to ensure that they fulfilled these conditions. The roles and responsibilities of the many organisations involved in the implementation, management and monitoring of the programme were complex and overlapping. This complexity contributed to the focus of the day-to-day programme management activities remaining on the implementation, monitoring and delivering the Health Check programme.

During the research, participants were critical of the lack of resources provided in terms of material provided by the national team to support the evaluation of the Health Check programme. It was evident from the examples they gave that they did not use resources such as frameworks and toolkits to assist them to evaluate the programmes they were involved in implementing and delivering, although they were aware of the range of frameworks and toolkits that were available. There were also examples given of evaluations that others had done in the past. When asked what they did actually use, participants explained that they then tended to use other people within the organisation who had experience of evaluating programmes. Inadequate financial resources and time were expressed as a core factor in preventing evaluation from being carried out.



## Chapter Six

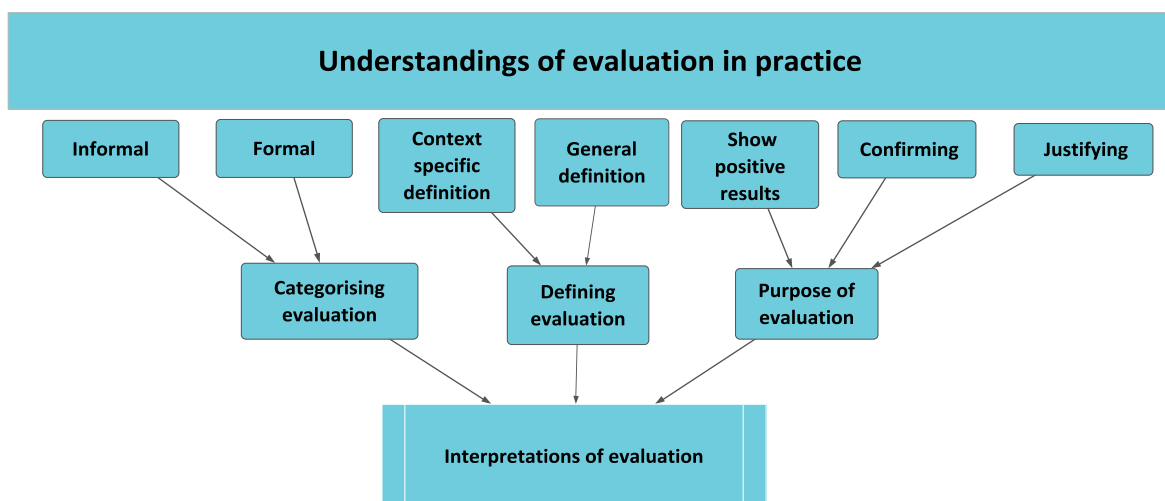
### 6 What is evaluation? The participants' perspective

#### 6.1 Introduction

This chapter presents analysis of the data that explores the participants' perceptions of evaluation. The analysis revealed that factors such as professional background and training influenced how evaluation was defined and described, both as a process and a concept. This was found in the context in which evaluation was being discussed and experience of the individual. It also illustrated that participants' understanding of evaluation was formed both from their own practical interpretations and from the knowledge they had acquired through their training and professional experience.

These varied perceptions of evaluation were reflected in the different terms and derivatives of the meaning of evaluation (figure 10). These were associated with a range of actions and concepts that tended to be associated with the treatment of data. Evaluation was described as being formal or informal, and this delineation illustrated how contextual factors influenced participants' attitudes to evaluation activities.

**Figure 10: Themes Understandings of Evaluation in Practice**



In the following sections, various interpretations of evaluation are discussed that illustrates the varied understanding of evaluation that existed in practice. What emerged was a mismatch between a scientific, statistical conceptualisation found in the guidance documents, professional background, training, and an experiential, anecdotal approach based on a more intuitive personal ethos.

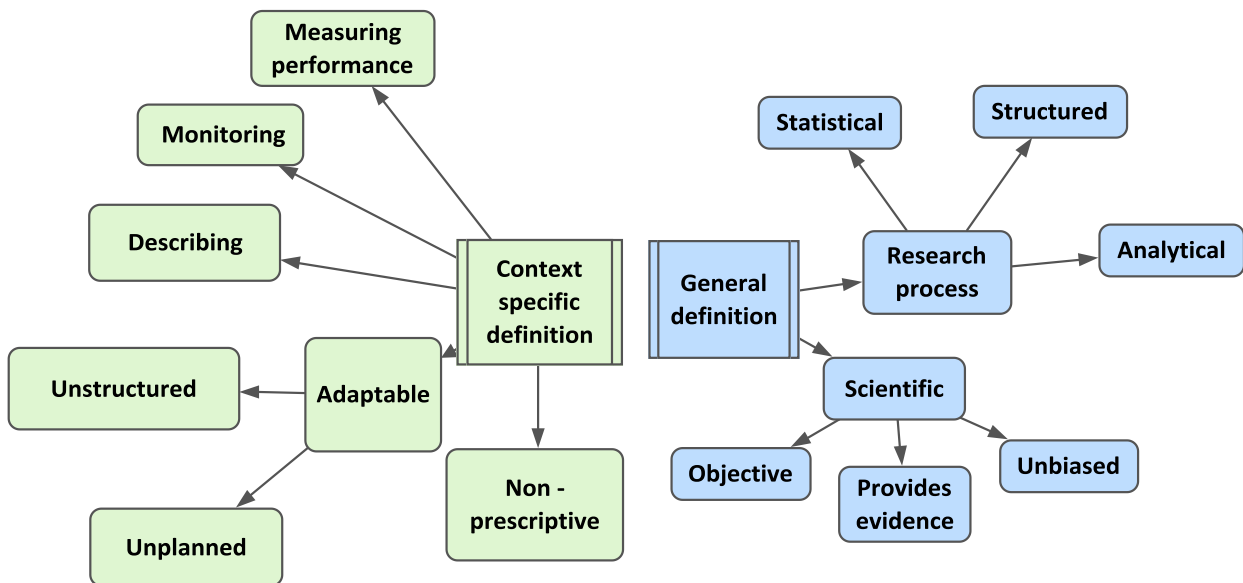
## **6.2 General verses context specific definitions**

Building a definition of evaluation proved difficult primarily because of the way the terms “evaluation” and “evaluating” were used interchangeably by participants. At the same time, the diverse understanding of evaluation presented by participants during interviews and conversations was determined by the context in evaluation was being discussed.

*"And when people say to me about evaluation I don't know what they mean by evaluate...Because there's so many different bits of the programme you can evaluate. And I suppose overall it's a combination of all those small bits of evaluation isn't it? ... (PHM2).*

Ultimately, two definitions of evaluation were formulated, general and specific, to reflect this diversity of understanding and the participants’ various perceptions of evaluation. These definitions illustrated an understanding of evaluation that was delineated as formal and informal according to the underlying tenets that governed the process and procedures illustrated in Figure 11.

**Figure 11 Defining evaluation**



Participants tended to perceive evaluation as a tool, placing an emphasis on what it could provide and what purpose it could achieve. Their focus was primarily on the operational aspect of evaluation, which involved counting, collecting and reviewing data to produce information. At the core of their accounts was the notion that evaluation is about proving or showing whether something is working, whether something is worth doing or whether something is worth continuing. Essentially, evaluation was perceived as having a temporal dimension and as being adaptable.

The researcher observed that knowing the principles of evaluation did not necessarily mean that participants applied them in practice, or indeed even planned to carry out an evaluation. In practice, evaluation was focused on examining how a programme is working or how the actions or activities that have been in place were meeting a programme's objectives.

### 6.2.1 The general definition of evaluation

A series of analytical themes were extracted from the data which provided a clearer understanding of the features of various definitions provided by the participants. A general definition of evaluation was formed from the responses that participants gave when they talked about how they perceived evaluation when it was not associated with a specific programme. During the interviews, participants were asked what the term “evaluation” meant to them. In their responses, all participants indicated that evaluation was scientific, systematic and rigorous: a process in which data was transformed into reliable information or evidence that was unbiased and therefore valid. In their view, evaluation was aligned with scientific research and the use of statistical processes to analyse quantitative data.

*"It can be research and I suppose it is best set up as a research project if possible to try and legitimise the results as far as possible" (PHL3).*

Participants gave what can be described as intellectual accounts of evaluation when they were defining it or when they explained what the term evaluation meant to them. They presented what could, in fact, be described as their ideal evaluation – there was a notion that when done properly, it was unbiased, and could be used to prove whether something worked or not.

Participants indicated a preference for results that were from evaluations perceived to be scientific and quantitative in nature. An evaluation in which data was statistically analysed was perceived as being robust. Participants explained that data treated in this way provided better evidence about what was happening within a programme, both in terms of cost as well as impact.

In this general definition, participants described evaluation as a concept and as a process, associated with demonstrating worth and value. The more abstract understanding of evaluation – as a concept – was articulated by all participants in their initial responses. Participants explained when evaluation was done properly, it followed the principles of research. It could provide the evidence that demonstrated the programme’s impact and effectiveness and a better understanding of whether a programme was worth doing.

*"Yeah I think evidence to suggest that what you're doing is worthwhile and is having a benefit to people" (PHM2).*

In other words, evaluation as a concept was about providing proof that "a programme is effective" or that it was having a "benefit". On the other hand, evaluation as a process was described as a way to show that "the aims and objectives of the programme were met", and "the programme outcomes have been achieved".

*"Well the term evaluation to me would be, you know, setting up a programme or pilot or a study and looking at the outcomes. Does it do what you planned it to do... is it fit for purpose, has it fit the purpose you assumed it would, so that's, you know, almost summarising the effectiveness of a project. That's what it means to me really" (PHM6,10)*

The features of the general definition of evaluation indicated that there was a shared understanding amongst participants that evaluation was a structured and systematic process. There was also a shared understanding of the importance for programmes to be evaluated, and this was to be done in a way that would ensure the resulting information produced was unbiased and reliable. These features were found to be theoretical and abstract as they were not discussed in terms of being applied in practice. They were more to do with demonstrating and understanding the core principles and approaches of evaluation and actually had very little to do with the day-to-day practicalities of evaluating a programme that they were currently implementing and delivering.

### **6.2.2 A context specific definition of evaluation**

When they started to talk about evaluation in the context of the specific programmes they were delivering, participants revised their initial definition of evaluation. This revised definition of evaluation was based on the participants' personal experience and the activities they were actually engaged with. In this context, evaluation was perceived as a more fluid, adaptable process.

It became apparent that expectations associated with a programme were integral to how evaluation was defined and viewed, and that this was very specific to the circumstances in which it was being used. When participants explained their understanding of evaluation, it was the way it was implemented in practice that was the focal point. At a practical level, evaluation associated with a specific programme was largely described as a process that included the gathering and storage of data and its use when required.

It was noticeable that the background of professionals and their status also influenced how evaluation was perceived and conceptualised. Participants who had specialist public health training, for example, emphasised the scientific research elements of evaluation. This was reflected in the use of more scientific terms when they were explaining what evaluation meant to them. This was in contrast to other participants, who did not have public health training. They used terms that were unscientific and were more reflective and descriptive in nature and emphasised the practical aspects of the programme. Variation in the features of these context-specific definitions suggests that participants at all levels had actually developed an understanding of evaluation which reflected their own job environment and its unique challenges.

### **6.3 Categorising evaluation: Formal (theoretical and abstract) and informal (driven by experiences) evaluation**

"Formal" and "informal" evaluation emerged as the main categories of evaluation defined by participants. Formal evaluations were conceptualised as a physical demonstration of compliance with national policy objectives, standards and targets. Formal evaluation took a number of forms, including a structured process to carry out an evaluation and the production of a document that provided information about a programme. It was something that is planned and put in place at the beginning of the programme. Participants explained if the conditions allowed, a "formal" or "proper" evaluation was what they would, or should, aspire to do.

Formal evaluation was associated with a form of research done by academic teams external to the organisation. External evaluations were viewed as being superior in terms of the information that they provided on one hand, but impractical in terms of being used to support decision-making in practice. As they might not sufficiently reflect the context in which programmes are implemented.

*"I suppose that is, that is, that... are the two forms, ... you're looking at a specific service and you're looking at within that service, evaluation of the data and evaluation of the impact of the service relating to the service users" (PHM5)*

Participants viewed a formal evaluation as an important aspect of the programme planning and implementation because it had the potential to provide good quality information about the programme. In addition, it was considered the best way to demonstrate that a programme or activity was working or was worth continuing to fund. Evaluations associated with assessing the financial impact of a programme were perceived to be formal evaluations. From the participants' perspectives, this form of evaluation would be done to gain an understanding of the cost effectiveness of a programme, generating information that could be used to determine if a programme was worth continuing to fund. The evaluation could be used to secure and preserve funding for programmes and their related activities.

The use of models and procedures generally associated with participants' notions of "the ideal evaluation" constituted a formal evaluation. All participants associated formal evaluation with scientific research methods involving the use of statistics and using an experimental research design. It was described as the approach that would be used to generate unbiased, objective information about the programme. Evaluation based on scientific methods would also provide the necessary information to improve service delivery and assist decision-making. Formal evaluation was viewed as the best approach to obtain the best evidence to demonstrate that a programme was effective.

Evaluation done in the form of research reduced bias and ensured that the evidence provided would be credible and less likely to be criticised. When asked to expand on this, PHL2 and PHL3 both explained that staff level of involvement with a programme helped determine how an evaluation was conducted. The more involved their investment with a programme's implementation and delivery, the higher the chance that results of an evaluation could be biased.

In contrast, the research suggested that participants held an alternative view about a related but quite different set of activities. Informal evaluation was described as the "ongoing evaluation", being done to provide learning opportunities so that the appropriate adaptations can be made to ensure that various elements of a programme were delivered as expected. This was a form of evaluation characterised by a tendency to rely on the use of tacit process and intangible outputs. Informal evaluation was based on experiences, practical intelligence and feedback. It

was described as the ongoing assessment of programme activities, including monitoring of programme performance and professional activities, and strategies for ensuring that set targets could be achieved.

#### **6.4 Process driven and product focused evaluation**

The understanding of evaluation that emerged showed that there were a number of different representations of how evaluation as a process was perceived in practice. As with the definitions of evaluation previously discussed, it was always possible to separate the description of how evaluation was conceptualised with how evaluation was done as a process. Participants frequently used examples of what they would do or had done to illustrate their understanding of evaluation.

The different conceptualisations of evaluation were also reflected in the different ways evaluation was used to describe the assessment of processes and assessing the impact of a programme.

*"Well when I said 'evaluating well' it's evaluating to show that it's actually it's happening, it's implementable and it's showing benefit" (PHL2).*

The processes associated with evaluation were also demarcated into formal and informal processes. What was ultimately achieved depended on which of these processes was being attributed. The emerging themes from the research indicated that evaluation as a process was viewed in varied ways. These ranged from it being an informal process associated with operational day-to-day activities that would justify and demonstrate success, to a more formal process associated with scientific research methods. From conversations with participants, it was established that in practice, a more formal process would potentially include reviewing progress and receiving guidance from a line manager, in particular establishing what should and should not be included in the process of the evaluation. These types of discussions may also include exploring what format the evaluation report should take, and asking for advice about how to write up evaluation reports.



Evaluation was perceived by some participants as a physical process that involved counting or measuring programme activity. The terms data and evidence were used interchangeably. "Having the data" was viewed as a way of being able to provide reassurance and proof of a programme being delivered. Others viewed it as a less tangible process that involved drawing on personal and professional experiences and values. This view of evaluation was illustrated when the participant's explanations involved notions of validation.

An important conceptualisation of evaluation started to emerge from the data – evaluation was perceived as being an instrument to provide information in a required format, in other words, a product. Evaluation as a product was conceptualised by participants as a physical output, such as a document in which information about the programme was gathered and presented. PM1's description of evaluation was a document that she had produced. Even in instances where evaluation was defined as a formal or structured process, the resulting document that was created could be referred to as an evaluation.

This conceptualisation of evaluation was based on the participants' accounts that a product, such as a report, which linked the monitoring of services with an evaluation process, gave the process a level of "respectability" and meant the results were less likely to be questioned. When asked to expand, participants explained that the process or document did not necessarily have to involve specific methods or approaches. However, it was understood that making the link with evaluation would imply that a structured process had been carried out, giving the resulting information a level of credibility even if no such processes were involved.

*"So it demonstrates a certain credibility with the investigations, I think, by looking at it (CM4).*

Some participants simply viewed evaluation as the specific output or document, created to describe how a programme was performing or demonstrating the performance of the team or individuals,

*"I think an annual report is a form of evaluation thinking about it... it demonstrates that you're trying you're trying to get control of the subject with the programme you're responsible for and committing resources for."(PHL1)*

It was the expectation of what was needed to be included in the evaluation that determined when evaluation was described as a product or physical document. Where evaluation was referred to as a written report or review, it was deemed to be a product that had to be completed and presented. There were a number of references in the research to evaluation as a written product or report. It emerged that a number of factors, such as who wants the report, a perceived need for more funding or the status of the person collecting the data and compiling the report, that actually determined when a document was described as an evaluation. In this context, what was described as an evaluation was usually far removed from the systematic, scientific approach that is expected and described in the various guidance documents.

As participants pointed out, presenting either a process or a product as an evaluation has both negative and positive consequences. It can be used positively to ensure that a service is protected, and to justify the continuation of funding, or in a negative way to justify why a programme or service can no longer continue. In the research, there were also both negative and positive views expressed about the value of evaluation as a process. The negative aspect of the evaluation process seemed to be associated with the additional work that it might generate, and the concern that it might not give evaluators what they want or expect. The positive view, on the other hand, was that evaluation when done well or properly was a good way of producing unbiased information about a programme.

*"... I think generally evaluation is something that people see, sometimes, they don't see the value of it and they think 'oh why have we got to do this?' Or, you know, it's almost like it's bit of sort of additional work that they don't really want to do and, but I think they need to be sort of realise the value, of it and it's important these days to, to be able to show an intervention and what effect it's having and if it's having any outcomes or not and if these are the ones you want" (CM2).*

## 6.5 Purpose of evaluation

As well as asking for definitions of the term evaluation, participants were also asked to comment on the purpose behind the process. As with the definition of evaluation, the participants' views of the purpose of evaluation was found to be influenced by professional affiliation and the context in which evaluation was being conducted.

In both formal and informal conversations, members of the task group explained the different uses of evaluation in their view. Evaluation, when described in general, was defined as a formal process or as a form of research, and its main purpose was to generate robust evidence or information to judge the worth of the programme or assess if a programme was worth continuing. However, the purpose of evaluation changed when it was described in the context of a specific programme. In the context of the Health Check programme, the key purpose of evaluation, as explained by both PHL1 and PM3 and PM4 members of the task group, was to demonstrate on paper their performance regarding to delivering the programme. In their view, the other purpose of evaluation was to provide the information to show or prove that the programme was working well. These three themes, demonstrating success, confirming, and justifying, illustrated the different ways the purpose of evaluation was perceived by participants.

Meeting official requirements was the common feature that was integral to the different forms of formal evaluation articulated by participants.

*"Well the purpose of evaluation ... is to make sure that what you're doing is worthwhile and that you are getting benefits out of it".(PHL2)*

This was qualified by statements about how important it was to understand how the programme was currently delivered in order to contribute to improving the programme. When participants talked about assessing the impact of a programme, or gaining an understanding of how the programme was doing, the term "evaluating" took on a number of meanings. It was found that "evaluating" was used to signify, for example, a process of when the data collected would be reviewed, assessed and reported, and when activities associated with the programme would be discussed with others. In particular, the term carried weight when it was associated with communicating with others and wanting to get feedback about the programme.

*“Well when I said ‘evaluating well’ it’s evaluating to show that it’s actually it’s happening, it’s implementable and it’s showing benefit” (PHL2).*

#### **6.5.1 Show positive results**

There were nuances to the answers given which suggested a complex array of beliefs as to why participants were being asked to carry out an evaluation, and what their own motivations were to comply. The underlying theme here was the emphasis on showing things in a positive light, whether this was in terms of the actual health outcomes, or any other perceived parameters, such as financial viability, political justifications or just a need to show compliance.

*“So I think most recently from a locality point of view is there are programmes that have been set up by people that are have been strongly supported by people within public health and within like I say a local authority background which when it comes to an evaluation we want to prove that it’s doing well” (PHM7)*

The terms “evaluation” or “evaluating” were used to denote the use of a systematic approach in reviewing data to generate the necessary information or evidence. These terms were examples that illustrated the varied representations of evaluation used in practice. The term “evaluate” was used in relation to demonstrating success in some form. Showing positive results appeared to serve a number of purposes, including the opportunity to show what had been done and how well it had been done.

*it's important that people are aware of the value that evaluation can have because if they want, for example, further funding to run a programme then they have to show an evaluation to say this is what we've achieved so far. (PHM1)*

The analysis showed that at the practitioner level evaluation is not actually about understanding if the programme is having an impact, but more about securing an individual's credibility, or giving their actions legitimacy. Fulfilling personal satisfaction was also a reason provided for carrying out an evaluation, to demonstrate personal effectiveness in terms of getting the programme up and running, developing and maintaining processes, and successful engagement with other organisations, professionals and groups. In the context of the Health Check programme, the members of task groups explained the key evaluation purpose was to demonstrate how well they had performed in relation to getting elements of the programme in place.

Participants further explained that they had to “pull things into the evaluation” suggesting that it was sometimes conceptualised as a product and not as a process. This aspect of the participants’ attitudes to evaluation provided further insights regarding their perceptions of the underlying purpose of evaluation.

*"Well the term evaluation to me would be you know setting up a programme or pilot or a study and looking at the outcomes, does it do what you planned it to do... is it fit for purpose, has it fit the purpose you assumed it would, so that's you know almost summarising the effectiveness of a project that's what it means to me really" (PHM6, 10)*

What emerged was the overwhelming need to demonstrate that something positive had been achieved. It was important that the information provided was positive in nature, the aim being to show that what was done had had some positive impact.

A concern voiced by participants was the negative connotations of suggesting that an evaluation should be done, in the first place. They explained that participants could be seen as questioning someone's ability, or indicating that they were not trusted. One participant expanded on this by indicating that when an evaluation is used rationally it can be positive. The other negative connotation associated with evaluation was that evaluation might be perceived as a way to show that a programme was not working. Requesting that an evaluation be done might be another way of indicating that a programme or service was no longer going to be funded. It was this potential negative use of evaluation that dominated participants’ views of it as a process and how the resulting information produced was regarded.

*"we talk about evaluation as if this is a nice clean process you know a good evaluation means that they get mainstreamed and a bad evaluation, it rarely works like that it's much more like if the evaluation, the evaluation is part of a number of things you know it may be that it's one of the enabling factors" (CM4).*

### **6.5.2 Confirming**

A common theme that emerged from the research, related to the purpose of evaluation, was "confirming". Evaluation was associated with providing proof to demonstrate that the programme was working. Money and time that was being spent could be accounted for, in other words, a form of validation.

A key purpose for evaluating seemed to be about confirming what was already known about the programme. Participants' explanations of evaluation encapsulated notions of validation and proof. They explained that evaluation provided the evidence to confirm that they are doing as expected. The term evaluation carried weight, in particular, when it was associated with communicating with others and wanting to get feedback about the programme.

*"Yes I think it's a form of evidence on, because that it's a form of evidence in terms of proving or showing where the funding's gone "(PHM1)*

However, those who recognised the value of the results, as opposed to the process in its own right, spoke of a moral element to their work, and were less likely to consider a successful outcome as their main objective of conducting an evaluation. All participants expressed the view that there was a need to be able to demonstrate that the programme was of benefit to patients.

*"you know whether we're looking at data we're looking at through put so yeah a tool would be able to enable you to demonstrate the number of people coming through and then possible variations from that"( PHM5).*

In this example 'to evaluate' is a physical process, the counting of patients using the service or just looking at data.

There was often an overriding emphasis put on the end-product in the form of a document which confirmed that action was taken, rather than demonstrating an effect of the programme. This suggests there is a disconnect between the actual and the perceived purpose behind evaluation.

### **6.5.3 Justifying**

This theme illustrated that one of the purposes of evaluation was to provide legitimacy to decisions related to the delivery of a programme. Participants explained that the term “evaluation” in itself had carried a certain currency, and importantly it is more likely that a decision associated with an evaluation tended to be viewed more favorably and was less likely to be questioned.

Evaluation in most of the participants' views was strongly associated with the concept of “evidence” to justify action, decisions and performance. In some cases, it was the term evaluation itself that was used to justify a decision or information associated with evaluation.

*"They know ... that they're getting a care coordinator so again they're getting somebody in the practice um to do some work but they know that in order for them to keep that person in the post it's got to evaluate well" (CM3)*

Participants frequently referred to government priority to show positive outcomes when discussing evaluating. In fact, evaluation itself was viewed as being a political instrument, as a process that would sometimes be used to corroborate a predetermined outcome or to further political priorities.

*"it's a political I find it a very political programme, a good programme and I feel it's been used not used perhaps that is the word my perception is that for a test bed for a local authority" (PHM6)*

In one example provided by PHM7, it was explained how evaluation had been used to support a decision to withdraw funding for a locally developed programme. PHM7 explained how when she asked for more information about what had been done to inform the decision, she was told that the programme had been evaluated. That was all the information she was provided with. Apparently, it was the term "evaluation" that provided the assurance that decisions were based on evidence gained from a process that was taken to assess the programme's impact and the ability to meet its objectives.

## **6.6 Summary**

Participants' divergent perceptions and views about what evaluation was as a concept and process were found to be determined by the context in which evaluation was being discussed. Evaluation was perceived not just as a process, but also as a resource to generate data required for scrutiny and monitoring by national and local organisations. Evaluation was also perceived as a resource in the form of data - visible evidence to demonstrate that professionals were doing what was expected of them and that elements of the programme were being delivered as expected.

The descriptions that formed the general definition of evaluation were ones that were associated with scientific and research attributes which ensured that the process of generating and analysing information was seen to be rigorous and transparent. There were ones where it was defined as an adaptable process that was unstructured and unplanned, with a focus on monitoring and measuring activities of the programme and for which the information provided was perceived as being subjective. The general definition was largely theoretical, broad and non-specific, offering little practical application.

The emergent themes also illustrated that a key distinction was made between formal and informal evaluation. The former being associated with a more theoretical and abstract concept, whereas the latter was associated with the more practical undertakings of evaluation, based on



personal beliefs and experiences. These meanings and interpretations of evaluation were found to be integral to evaluation in practice and could not be disassociated with how evaluation is actually conducted.

Evaluation in practice emerged as a process that served a number of purposes. Firstly, it was perceived as a product that visibly illustrated that a programme was functioning and being delivered as expected. Secondly, it was used to legitimise a course of action, and thirdly, it was defined as a process to review data and determine what information should be provided. The term “evaluate” was also used in relation to assessing personal achievement, in the form of individual performance.

The analysis revealed a mixture of organisational, professional, individual and political factors influence views about what evaluation was intended to achieve and why it needed to be done. The definitions of evaluation were in part based upon the participants' training, their background, and the context in which evaluation was being discussed. The meaning and interpretation of evaluation, as expressed by the participants, was also influenced by the context in which evaluation was being discussed. Some distinct categories of evaluation that emerged from the analysis can be used to explain how evaluation was defined, the purpose of evaluation in terms of what is achieved, and the different dimensions of evaluation. These accounts and descriptions also provided some insights into the concerns and issues currently facing the health professionals. Whilst there was an understanding of an expectation to evaluate the programme, the delivery of the programme remained their priority.

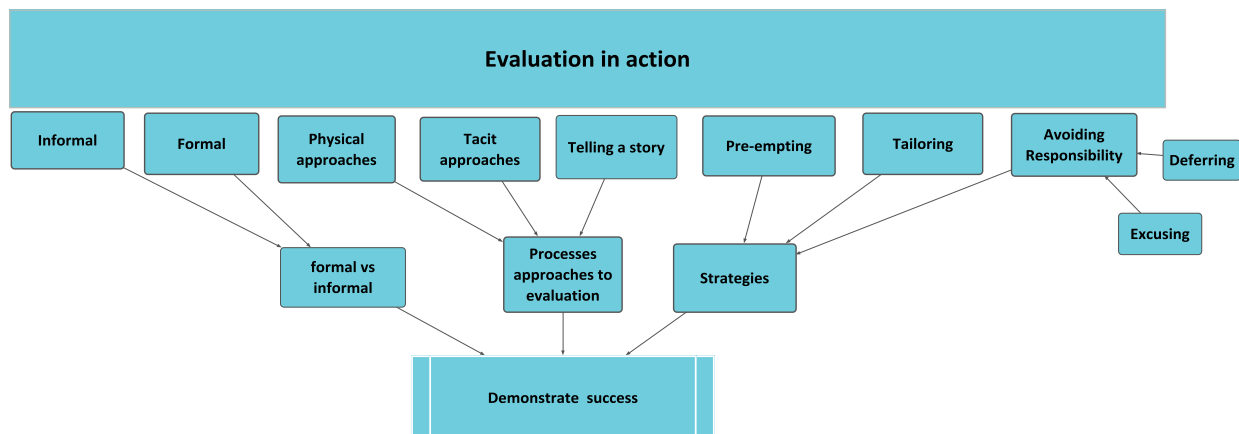
## Chapter Seven

### 7 Evaluation in action

#### 7.1 Introduction

In Chapter 7, the practicality of doing evaluation in the context of the Health Check programme is explored identifying how evaluation is carried out, what it achieves, and what contextual factors and underlying motivators influence how evaluation is conducted. This chapter focuses on the relationships among the themes that provided an understanding of how evaluation was conducted in practice. The themes were formed from participants' descriptions of how they had carried out evaluations in general, and from observations of what they were actually doing regarding evaluating the Health Check programme. This deeper understanding of how evaluation was carried out in practice builds on the themes that have been presented in previous sections.

**Figure 12: Themes Evaluation in Action**



The themes presented in this chapter include informal and formal evaluation processes and strategies. Together they explain what participants were doing with regards to evaluation in practice.

## **7.2 Informal evaluation (intangible output) and formal evaluation (tangible output)**

The analysis revealed that the delineation in how evaluation was defined was not constrained to the way it was conceptualised. This demarcation was also found in the context of doing evaluation. After spending 12 months with the participants, it was observed that this delineation between formal and informal evaluation formed an important part of how participants distinguished between the different processes of “doing evaluation” as a means of generating different outputs. This demarcation of “informal” and “formal” evaluation illustrated how the outputs that were ultimately being produced helped determine what form of evaluation activities would take in practice.

### **7.2.1 Formal evaluation (tangible outputs)**

Formal evaluation was associated with the external presentation of information about a programme and its process, whilst informal evaluation was associated with the oral communication of information to inform decision-making and to make judgments about the outcomes of programme activities. Formal evaluation was described by participants as a formalised process that is carried out to assess the impact of a programme, and tended to be a report or review of the programme activities done at the request of another organisation or professional. It was viewed as a way of providing information that was objective and was less likely to be biased. Conceptually, evaluation as a formal process was considered to be credible, and as such would produce the best information and knowledge about a programme. It was expected that it would give a true picture of the programme and its benefits. This form of evaluation was viewed as hard to operationalise.

However, it was observed that in practice the participants did not generally put this understanding and knowledge of evaluation into practice. Instead, a range of activities and systems were developed to manage data and to monitor the performance of the programme. Programme data was the material that was then used to support narratives about the programme, to explain the challenges of delivering aspects of the programme as well as assessing the progress of the programme and its ability to meet its targets. In practice, formal evaluation tended to be associated with the process of producing a document such as a review or report. Doing an evaluation involved describing how some elements of the programme had been

delivered and what had been done in terms of process. For example The Health Check Annual Report, was described as being “an evaluation”.

The desired outcome tended to be identified in advance with regards to evaluating a programme. The implications of this were that the process of doing an evaluation involved ensuring that the appropriate information correlated with an identified outcome. These were described as “formal” evaluations, according to participants, and tended to be done to meet an expectation to demonstrate that the programme was of benefit in some way. Processes involving the collection and management of the programme data were also associated with formal evaluation. Specifically, “pulling together” data or information about the programme was described by participants as the action of doing evaluation. This data then formed the basis of the reports that were presented at regular meetings or groups external to the PCT task group.

Participants explained that in their view formal, or “proper”, evaluation made it hard for the results to be biased. Further, an evaluation associated with research was considered superior because it would be structured and underpinned by scientific methods. This view was strongly held by the participants who were public health consultants. For them, formal evaluation should be done as a research activity if the results are to be taken seriously. Opinions about how and when it was best to use a formal evaluation approach varied. Formal evaluations were sometimes described as ones that were commissioned or carried by a national organisation or someone external to the programme. Every participant during their interview made some reference to an evaluation that was done by external groups or organisations, and provided their opinions on the value and acceptability of these forms of evaluation to those monitoring or delivering a programme. This led to some interesting discussions with the participants about who was in the best position to evaluate a programme. The view was that those involved with implementing a programme should not evaluate as they might have a stake in showing that programme was doing well. One of the best ways to mitigate this kind of bias was to get someone external to evaluate the programme, and for them to use a structured approach. However, the measures that were required to reduce bias were viewed as both positive and negative. As the participants explained, the positive aspect of having those involved with the programme also evaluating it was their high level of knowledge and understanding of the programme. The negative aspect of this was that they were more invested in the programme and therefore may have had a desire to provide evidence that would show that the programme was having a positive impact.

Formal evaluation was also represented as a physical document that was produced to provide information about a programme. In the examples given by participants, a formal

evaluation was the report in which programme staff described the programme. The formal aspect of evaluation in the context of the Health Check programme was the external presentation of information about a programme and was a way to make information visible.

Formal evaluation also included using a formalised approach to evaluate a programme. According to participants, using statistical methods to analyse the programme data, or applying a recognised framework to guide the collection of data was formally evaluating the programme.

However, participants pointed out that there were limitations to the use of a formalised approach and the results of such an approach were viewed by some of the participants with scepticism. As PM3 explained, using a formal approach has the potential to provide nothing more than what is instinctively known about the programme, simply a way to formalise information that is already known about the programme.

*"... I mean looking at you know elsewhere in the PCT there's been a very you know a very formalised evaluation done of the health trainer programme which has followed a you know followed a procedure that's been drawn up and devised and you know done but I don't know whether they've particularly got any more out of that than the way we've done it which is sort of an instinctive thing what do we want to look at and if we look at that how do we do that and agree as a group how we how we do it, I don't think there's any gains because, I don't know if there is any proven way of evaluating that isn't that isn't without a flaw". (PHM4)*

A key limitation associated with formal evaluation was the potential loss of “soft intelligence”. According to PHL2 and PM3, it is the soft intelligence that enables a real understanding of the programme and which a formal process is not set up to capture. In their view, this kind of information cannot be captured by a recognised, more formal process.

### **7.2.2 Informal evaluation (intangible output)**

The theme relating to the informal aspect of evaluation was formed from participants' descriptions of processes that were considered to be part of the day-to-day activities aimed at ensuring that programmes they were involved with were meeting the expected requirements.

According to them, informal evaluation was a series of actions undertaken to ensure that the data required for monitoring the delivery and performance of the programme was available and retrievable. This was the form of evaluation that was an integral part of the everyday experience of implementing and delivering a programme. The physical process such as counting, collecting and getting feedback as well as using knowledge and experience to ensure the activities they were involved with were what was required.

There was a strong reliance on the use of intangible resources, such as practical intelligence and professional experience, in this form of evaluation. Informal evaluation also drew on the use of common sense and reviewing the actions of others. It was tacit in nature. This was reflected by many references made by participants about the use of intuition and their need to engage in discussions with other participants and colleagues about data, and what it represented. As a result of the tacit nature of informal evaluation, both the processes and outputs tended to be intangible.

*“it was not looking at effectively the outcomes of the programme it was looking at the outputs of the programme really” (PLH3)*

Informal evaluation was found to be primarily based on personal and professional experiences and practical intelligence. Information was gained and shared through verbal communications and was rarely written down.

*“But a lot of the evaluation I do, to me is informal, it's in my own head of how am, I how am I doing, how's the programme going, what problems are raising their heads, what do I need to deal with?”(PHM3).*

The way that participants engaged at meetings demonstrated that an integral aspect of evaluation was in the everyday, personal assessments of activities associated with implementing and delivering the Health Check programme. This included ongoing assessments of performance, of individuals and of elements of the programme, and was communicated through continuous feedback and verbal communication.

*“so I've been consciously asking for feedback. I am monitoring it in terms of how the process is working” (PHL2)*

This verbally communicated day-to-day assessment of the operational aspects of the programme provided insights and information which was actually used to support decision-making in the PCT environment. Problems with programme delivery were identified and discussed at regular meetings using these insights and information. One example from the Health Check programme was the challenge of low uptake of invitations to access the programme. This issue was being monitored in data collection and was a frequent topic at the CVD task group meetings, featuring as a standing item on meeting agendas. This continual oversight of this aspect of the programme's activities was referred to as evaluating, largely related to the amount of time spent reviewing data before and during the meetings. This example demonstrates the ongoing aspect of informal evaluation.

A significant part of ongoing evaluation related to the establishment and maintenance of relationships with other professionals involved in delivering the programme. Participants were observed to be investing time and energy to assess the nature of their relationship with others. Evaluation in this context involved the assessments of decisions and actions made by those involved in delivering the programme. The consequence of poor relationships with others was frequently discussed in particular the impact of lack of engagement with the programme. Non-engagement of with some of the GPs in the area was considered to be failing on the part of the programme team and this needed to be rectified. There was a recognition that successful delivery of the programme depended on everyone taking part and doing what was required. Both PHL1 and PHM3 constantly reviewed their relationship with GPs and other members of staff. A number of conversations during the team meetings focused on exploring what measures needed to be taken to ensure that any decisions being made did not have a negative effect on the relationships they had with the GPs or the staff who were delivering the programme. The description of the senior manager's daily activities illustrated that an essential aspect of evaluation in practice was relationship building (5.31 remit of the senior manager).

### **7.3 Processes: approaches to evaluation in practice.**

This section of the results focuses on the approaches and the different processes that participants described that they used or were planning to use to evaluate programmes in general, and the Health Check programme specifically. These were divided into two themes that reflected the different ways that participants approached evaluation – either “tacit” or “physical”. It was observed that moral and cognitive reasoning were drawn on to a different degree to support these two approaches to evaluation.

#### **7.3.1 Physical approaches**

The themes that formed the physical processes illustrate the mechanical aspects of doing evaluation in practice. They were mechanical in that they were comprised of the physical processes that participants described using when they went about evaluating a programme. These processes fall into two types: the ones that involve how available programme data is managed and treated in order to produce outputs such as reports and reviews; and processes related to the dissemination of these outputs.

It was observed that the physical process of evaluation included a range of operational activities that were being carried out by the participants to ensure that various elements of the programme were being delivered as required. These operational activities were described by participants as fundamental to the process of evaluation in practice, and were largely related to the collection of data and use of data to provide reports on programme activity. These activities included counting, collecting, sorting, storage and retrieval of programme data. It was observed that a significant amount of time and effort was used to collect and store programme data. When asked why there was so much data being collected, participants explained that this was important because it was best to have all the necessary data to hand. Only basic data analysis was observed being carried out. This analysis was presented in the form of tables, comparing performance among different GP practices. This information was presented, discussed and further analysed at the monthly meetings.

The collection of data and its storage was the main preoccupation of the core members of the task group, and most of the activities described as evaluative involved gathering, sorting



and storing data.. Participants described the collecting of data or evidence as a way of being able to show how well the aims and objectives of the programme were being met. This "pulling together of data", as it was described, was part of doing an evaluation.

*"The data the process of doing that you may be collecting might not be totally relevant, a year, two years down the line, but the key thing I think is to establish the process. One of collecting the data, secondly of trying to process the data into some meaningful format" (PHL1).*

The activities associated with creating a document were associated with evaluation. The creation of an evaluation as a document did involve the use of methods that were described by participants one that you would use to do proper evaluation. Instead the process included the collation of data in order to produce documents and reports to describe the programme's activity and performance. PHL1, explained that producing an annual report was equivalent to doing an evaluation, as it involved sorting and presenting data and, importantly, it was having to make decisions about what information should be included to show how the programme was progressing. An annual report was produced annually to provide a descriptive overview of what the Health Check group had been doing. In fact, the analysis suggests that participants used data to provide information in a format that would avoid the need to have difficult conversations about the impact of the programme, rather than information that would shed light on the evidence of programme impact.

In other examples, "doing evaluation" described the physical process of counting of patients using a service, or just looking at data. This included the systematic collection of programme data used to monitor a programme's activities. This physical approach to evaluation was reflected in PHM1's description of how she went about doing the evaluation of a programme she was involved in delivering. She explained that she was simply getting all the programme information that she had collected while she was "going along" and would put it all together to produce an evaluation. This was in addition to meeting up and having a face-to-face conversation about what was going on to put the data into context.

The system was created to meet a number of functions, including to monitor performance and to prepare reports:

*"there is a system in place to get data collect data on a monthly basis essentially"(PHL1).*

The core task group were required by DH to collect a range of data from the practices, including activity data such as a number of patients who were invited and a number of Health Checks done. The core team had access to additional and clinical details for each individual that had had a Health Check, however, the only information they were required to provide to the SHA and the national team was the percentage of eligible patients who had had a Health Check assessment done.

*"the vast majority of that data ...it's the data anyway that's required for the Department of Health"(PHM4)*

In this example, evaluation is a physical process, the counting of patients using the service or just looking at the data.

*"The things that we were measuring there were things like erm the uptake rate and awareness of the programme and erm outcomes of the programme in terms of whether people were identified as at risk or not erm and referrals just simple erm numbers of referrals into different lifestyle programmes and back into the back into the erm practice for further follow up but that was it was not looking at effectively the outcomes of the programme it was looking at the outputs of the programme really but that was about it was to inform the development and roll out of the programme more broadly than the pilot area so it was the evaluation of the process as well as the effectiveness of the programme per se if you know what I mean ..." (PHPL3)*

According to participants, evaluation tended to involve reviewing data to give a credible account, in terms of what was done about delivering the programme activities

It was observed that service data was used for the purposes of "evaluating" but evaluating in this context was using the data in a way that involving little interpretation. The main

concern was to be able to provide an account of what had been delivered and what had been done from an organisational point of view.

Evaluation in the descriptions included the actions taken to monitor how elements of the programme were being put in place, checking if national standards were being adhered to, reviewing, and managing relationships with other professionals involved with delivering the programme. In relation to the Health Check programme, priority was placed on the operational side, in terms of focusing on monitoring the programme activity and how it was being delivered and checking that it was being delivered at the required standard.

When participants described how evaluation was done in practice, they tended to include references to the collecting of data and the development of the system they had put in place. PHRM for example explained that they had developed a regional data solution using a specific software system to capture and store programme activity data. PHL1 and PHM3 had also developed their own local solutions. The result had been what PHL1 described as a comprehensive collection of data about the programme at all levels in the system. "Evaluation" according to the participants in this context was the reviewing and checking of the data in systems and the system itself.

*"Me - So you mentioned early evaluations and I just wanted you to expand on what you mean by that in terms of how they were done?"*

*PHL3 - 'Right so, so obviously we had activity monitoring systems put in place early on to ensure that we were keeping an eye on how practices that have been given the resources to start doing the health checks programme were actually delivering in line with the expected activity that we required of the investment in the in the programme'"*

The pressure for the CVD task group to ensure that the information required for the monthly, quarterly and annual targets to be delivered meant that a significant amount of time was spent reviewing and checking the activity data for the Health Check programme.

The monthly figures were provided by practice managers from GP practices to PHL1 and PHM3. The information provided by the practices was used to monitor both the process and progress of the programme. Based on what the information showed, action needed to be taken in order to ensure that the annual targets for the programme could be achieved. GP surgeries that

provided incorrect data or no data at all were contacted and asked to provide an explanation to help them understand what was happening. This process, according to PHL1 and PM3, was a form of evaluation. They were evaluating the process, as they were engaged in reviewing data and making judgments about the quality of the data and using this to decide what to do next. Evaluation in this context was informal, and driven by the operational and reporting requirements of the programme.

In this situation, the participants were being reactive, collecting and displaying the necessary data needed to demonstrate to national and local organisations that the CVD task group was successful in meeting the national targets.

### **7.3.2 Tacit approaches**

A core category – tacit approaches – was formulated as the themes illustrated a clear pattern of reliance on the use of institutional and personal knowledge. The analysis revealed that participants actually relied on a range of reasoning systems and processes to make judgements about the data they were collecting and about how it should be used. On one hand, the resulting information could be used positively to ensure that services are protected and funding is continued. However, on the other hand, it could also be used in what was described in as a negative way to justify the decisions to no longer fund a service. The form of reasoning that was applied to arrive at a decision included more than just moral in nature but also included reasoning was practical.

*"... if the project has kind of political backing or if it's seen as the answer from somebody who's important or if it's there's a clamour for it in practice then it will tend to go forward..."(CM4)*

Participants were observed to be drawing on a mixture of practical and moral reasoning as a way to balance their competing obligations to show success in relation to national and local organisational and political expectations. At the same time ensuring that they delivered a

programme that was beneficial to members of the population they served. As a result, their approach to evaluation tended to be reactive.

Participants used information gained from conversations with others who were involved in delivering or commissioning the programme. This constant communicating and feedback about the programme's activities provided the main form of information that was used to support decisions and to make judgements. The tendency to use the information gained largely from verbal communication was observed during the monthly meetings. It was observed that an assessment of a process or activity was done through verbal interactions.

*“...it would be interesting to actually ask at the network meeting how they manage their smoking referrals they must have the same issues how do they how do they, know how do they get their outcomes from the smoking” PHM3*

Maintaining personal and professional relationships emerged as an important aspect of delivering the national programme locally and evaluating responses to certain decision and requests also formed part of this process. Participants were observed to be evaluating personal and professional interactions and relationships to ensure that other professionals were “on board” or were doing what was required. This was done either collectively by canvassing the opinions or advice from others members of the group or personally by directly contacting individuals to get feedback and their views. At all of the meetings attended, at some point in the meeting there would be a discussion about how best to manage a relationship with either an individual, service provider or another professional group. The participants at the meeting would voice their opinions and then together they would assess the pro and cons of a number of approached and then collectively agree on how it will be addressed. The concern about not wanting to do something that would affect the relationship with others was voiced by participants in the interviews.

This extract provides insight into the tacit nature of evaluation in practice, it also illustrates the reasoning processes that are involved, as well as how participants interact with others.

*“– Um ... I again I go back to the information analyst who would but again you look at your administration at first and how that data's collected and whether that's you know an accurate way of collecting that data whether it's you know it's valid, you then go to your information analyst who would then look at the data and be able to put it into you know an population level or ward ...And you then go onto I suppose, another team member who is able then to then look at that data and say put it into context of what the programme's, about, what the population's about and just say is it doing it, you know, so you need background knowledge about what ... what you're trying to impact, so with the health check programme, I suppose you're looking at CVD risk you're looking at and you're looking at all the other care pathways...” (PHM5).*

Feedback featured as an important means of gathering information that was then used to support decision-making. These interactions between the participants were fundamental to the decision-making process. The information gained from conversations and feedback was interpreted and assimilated by the participants. The participants' accounts indicated that they relied on moral and cognitive reasoning to then support their interpretation of data and information. The result was the creation and use of intangible resources that could only be shared amongst those who were involved in delivering the programme at a local level.

*"so I've been consciously asking for feedback. I am monitoring it in terms of how the process is working "(PHL2)*

It emerged that the term evaluation did not represent conventional processes that were described in the general definition of evaluation. Instead, evaluation related to the processes that tended to be context specific. For example, programme data presented at the meetings were discussed in the context of the GP practices they originated from. A narrative was provided to supply additional contextual information. It was this range of information that was then used to determine what action, if any, was required. At every meeting that the researcher attended, data collected from the GP surgeries delivering the programme was presented by PHM4 in the form of tables showing the number of people who were invited and a number of people who had had a Health Check. PM4 also included some basic calculations so that comparisons could be made

among the practices, so that it could be seen which practices were not meeting the targets for the number of invitations sent and assessments done for the month. These tables were then examined by all who were present at the meeting.

The resulting conversations tended to focus on what the data was failing to reflect. Questions were asked about whether there was information available about a particular practice. If someone did have access to information, they would explain what was happening to give more meaning to the numbers. This additional information was then discussed and sometimes would be verified by someone else. After these discussions, decisions would be made about what action needed to be taken. The decision to take action was not based on the figures alone, but on the additional information that was added. Based on the additional information, even if a practice was not meeting their target according to the figures presented, the quality of data might be questioned and action might not be taken. This process was described as evaluating, because data was examined, discussed and validated using a mixture of cognitive and intuitive reasoning. It was only after these kinds of conversations in which data was examined and clarification sought from others about what the data represented, that it was validated and put into a report or included in documentation for circulation.

Having a written evaluation plan or document in place was not considered necessary as it was viewed as a sign of mistrust. It was considered better to explore what was considered more important, which was actually the quality of the verbal communications taking place between the different parties involved. In the case of the Health Check programme, the presented data was explored through discussions at the meetings. Participants at the meetings gave their opinion about the data and added their personal understanding and interpretation. Evaluation plans and strategies were discussed with members of the different directorates, to establish what would be acceptable and to secure agreement about what data would be requested or could be collected before starting a process that involved assessing what was being done.

*"the strategy if not written down, if it's not written down was discussed amongst the team" (PHM6)*

These activities that were primarily tacit in nature was observed when participants were describing how they go about evaluating programmes or projects that were locally instigated, it was through these examples that the use of tacit knowledge was most commonly illustrated.

The relationship among the professionals was a core aspect of this tacit process. It was through these relationships that information was shared which was then used to inform or support decisions made. It was observed that participants used a mixture of cognitive and value processes to review the data. Depending on what was required, the data was then used to form a description of the activities or to produce a report or a table of data for the GP practices. The more detail that was required, the more effort was entailed to transform the data into the type of information required. The outcomes of these deliberations were rarely written down.

### **7.3.3 Telling a story**

The value of the data was determined by its potential to serve a purpose in the future. The assessment made of the data in the systems was described as evaluation. These activities were found to be tactical in nature and included a form of forecasting or second guessing of what could be asked for by the organisation, and was based on their knowledge and understanding of the political and organisational impact of the programme.

The theme of 'story telling' was formed from the references that were made about the requirement for a verbal explanation, or the story behind the data or information being provided. Narrative emerged as a theme that reflects an important aspect of evaluation in practice. Narratives were considered an important part of understanding what was going on and to assess the impact of the programme. The need for data to be accompanied by a narrative illustrated that an important part of how participants gained an understanding of the programme's progress was through having a conversation about what was going on with the programme and the reported data. Listening to a story or an explanation was actually found to be part of how the participants evaluated or assessed the credibility of the information provided. This was either in the form of feedback with those involved in delivering the programme or a discussion about problems encountered.

Data that was accompanied with a story was given much more attention. A story provided the missing intelligence to contextualise or explain the data. The senior manager, the regional manager and public health consultants, in particular relied on the data being accompanied by a story. PHM3 explained that she valued any additional verbal information given to her, particularly if the figures that someone provided were not making any sense or if they had indicated that things might not be going well with uptake of the programme. In her view, it was



important to get the background, as this provided the additional information she could use to determine if the programme was progressing well.

PHRM1 explained that it was more important to her if she was told a believable story. She explained that believing a story and accepting it was determined by who was telling the story and her levels of trust with the person. PHRM1 explained further how it was important to meet to talk over things to find out more about programme performance and not to solely base decisions on the data alone. Meeting someone was a good way to assess if the story being told was believable, she added. She considered these factors before she could make a judgment about the information being presented. Based on what she was told about the information, she could determine whether she needed to take action or not.

*“It’s more it’s more soft narrative as opposed to hard data....those that are very good at selling a story will be ticked as green” (PHRM1)*

The importance of having a narrative in the form of a story or an account was also observed at the task group meetings, where members of the CCGs would provide a narrative to accompany the monthly figures from their particular CCG. One of the reasons for attending the meeting, one of the CCG manager explained, was to be able to communicate what the figures failed to show. She felt that presenting the figures without that story made the figures meaningless and increased the potential for them to be misinterpreted.

#### **7.4 Strategies: “pre-empting”, “tailoring”, “avoiding responsibility”**

The themes in the section provided a deeper understanding of the strategies that emerged that were instrumental to evaluation in practice. These strategies were the ones that enabled participants to meet both their organisational and political obligations to show successful outcomes, as well as their personal and professional obligations to deliver a programme.

## 7.5 Pre-empting

Pre-empting emerged as a prominent theme which encapsulated the strategies that participants engaged with and the actions that individuals took to ensure that they could readily access data when required. Pre-emptive strategies were a form of forecasting, in other words, thinking through what might be requested next. This was a collective activity, as observed during the meetings, where participants engaged in discussions about the data systems and collectively thinking about what might be requested next. In practice, “pre-empting” involved collecting and managing data and information, but doing nothing with it until it was specifically required or requested. “Pre-emptive” strategies were about participants feeling prepared, and about being on the defensive. The information generated could be used if external demands were made or the value of the programme was questioned.

*“Yes I suppose it’s a bit may be a bit anal from that point of view because you’re not quite sure as time goes what you need to collect. All you’re intent on is establishing a data collection system. The data the process of doing that you may be collecting might not be totally relevant a year, two years down the line, but the key thing I think is to establish the process. One of collecting the data, secondly of trying to process the data into some meaningful format” (PHL1)*

From both the formal and informal interviews with participants, it was apparent that a significant amount of thought had gone into developing sophisticated systems to both capture data and store programme data. A full and comprehensive data collection and storage system was in place for the Health Check programme. Participants explained that while this data repository served a number of purposes, it primarily served as a resource they could draw on when required. It was developed initially for the programme so that the patients' risk calculations could be generated, but over time PHL1, PHL3 and PHM3 explained that other forms of data were added into it, resulting in a comprehensive data collection system which could be drawn on or shared with others.

The collection and maintenance of data was found to be an important element of pre-empting or being prepared. Participants acknowledged that a significant amount of thought and

effort had gone into developing and putting the system in place, although only a fraction of the information gathered was being used. The data collected was described as being “more than was required” for performance monitoring and what was required for reporting purposes.

*"yes um and all the data has been collected there has been unbelievable rigorous data collection" (PHL2)*

Participants described the collection and storage of data as being pre-emptive. Over the years, the CVD task group had accumulated a comprehensive set of data for the Health Check programme. It was explained by PHL1, PHM3 and PHM4 that as much data as possible was collected and stored on local systems. So this has meant they could have easy access to the data when it was required. In addition, they were able to access an additional dataset collected by the external software company, including data provided by the GP practices about their programme activity every month. Both PHL1 and PHM3 admitted that this was much more than was required for the performance monitoring requirements. However, they felt that it was necessary to collect as much data as possible in order to ensure that the relevant information could be provided to answer questions later on.

*"And maybe evaluation is the same basically. Is to pre-empt issues, have facts and figures to hand about what performance ... was the reason why we did it to have facts and figures available for fending questions that might get thrown at you"(PHL1)*

It was explained that the Health Check programme's comprehensive data system was developed as a result of reviewing the data that was initially collected for the evaluation of the pilot of the programme. This initial exercise enabled the task group to identify what other data should be collected so that in the future, when the programme needed to be evaluated, they would have the right data.

*"It might not become a topical issue but when it does we've got it essentially (PHL1)*

These were examples that suggested that a holding position was maintained until an evaluation was requested. The available information was then pulled together into a report or evaluation document and passed on to the relevant organisations or bodies. What went into it was determined by who was preparing the evaluation and what it needed to show.

## **7.6 "Tailoring" strategies**

Tailoring emerged as a theme that exemplified the way participants modified their approach to evaluation in order to meet organisational and professional requirements and obligations to demonstrate success in some form. A key feature of "tailoring" was not being explicit about the methods or the approach employed to carry out an evaluation.

*"You know it might be two years, three years, twelve months, six months depending on if it's a pilot or how that's working and then there was no nec ... we didn't necessarily have a set format, we would just go ahead and evaluate"(CM2).*

A key aspect of tailoring was not to dictate or be directive about how an evaluation process should be undertaken. This flexible approach allowed for the exploration of data and information so that positive outcomes could be demonstrated. In this example, PHL2 gave her view on the process which was not governed by any structure as long as the right information was produced:

*"there was a book of instructions of vaguely how you could do it and as long as you ended up with the information that they wanted you could do anything you liked" (PHL2)*

Frequently, participants expressed that it was important not to be prescriptive when planning or thinking about evaluating a programme. Having the freedom of expression for themselves and for others was considered to be an asset. Being flexible and not being explicit extended to the way the programme's evaluations were to be commissioned and assessed. This strategy allowed the approach to evaluating programmes to be iterative, unstructured and unplanned. This focus on not being too specific capitalised on making sure that negative aspects of the programme's performance were not reported.

One of the managers who had commissioned an evaluation in the past explained how he tried not to be too prescriptive when asking for what he wanted when he had paid to do an evaluation. He explained that if he had to set out exactly what he wanted, there was a danger of not getting the answers that he needed. Not being too prescriptive enabled additional information to be gathered. It allowed him to be open to taking in new information that may not have been thought important but could be justified under the guise that it can be used to show that an activity or a programme was working, or that there were other benefits that would not have thought of at the beginning of the process.

*“you know, you put an intervention in place to achieve one thing but actually it's a totally different affect and, you know, you might think ‘we didn't expect that but that's really good’ so if we'd, design, you know, we don't want I think want to be too prescriptive and possibly stop things like that from happening or being captured if you like” (PHM2).*

This flexible approach meant that legitimate reasons could be given to reject the findings of an evaluation if it did meet the expected requirements. According to the participants the results of the Health Check programme were already determined, implying that any form of evaluation would need to be one that enabled the right data to be collected to support these preordained results. In other words, it was the programme's results that would drive the evaluation process and whatever information was generated had to reflect these.

*“so I think for some people it is I think that you know it when you're looking at evaluation if you're looking specifically at evaluation questions, the questions can be skewed to not identify failure” (PHM7)*

The tension between having to meet national demands with having to meet local ones meant that participants were making decisions about what information needed to be produced. This tension was illustrated in many accounts in which participants articulated their concerns about needing to meet the DH targets and, on the other hand, maintaining a service that had already been established. There was a shared understanding that evaluation, as a process, needed to be tailored to provide the necessary evidence that the programme was doing what was required. These examples of doing an evaluation were ones in which participants adjusted their approach to be in line with organisational or policy demands.

*"I suppose we evaluate around our targets, so that in a way to me probably makes your mind up the bits you're going to evaluate but different members of the team have different focuses on evaluation" (PHM4)*

Also the examples provided by participants suggested that their actions allowed them to tailor the information that was being collected:

*"But over time of course, success isn't just about that it's about getting enough people having the checks but... the quality of the checks... so the focus of the evaluation changes because you've only got a limited amount of time so you would evaluate...." (PHL2)*

Participants tended to use their own personal judgement to determine how to present data as useful information, and whether it should be labelled as an evaluation or not. A preoccupation of task group members was with being able to demonstrate that the desired objectives were being met. To identify the data and information that was most appropriate a retrospective approach to the collection and assessment of data this allowed participants ensure that happened.

*"I guess from my perspective it will be good to see the whole thing through, really throughout doing the project I have kept on looking back at the outcomes and planned events to match the outcomes to make sure we're going to meet them"(PHM1)*

This was considered as an acceptable way to approach evaluation, as it involved an assessment of the data and making a judgement about what purpose it would serve. The main concern was to ensure that positive aspects of the programme were reflected to others, either verbally or in a report.

This flexible approach to the process of evaluation was observed at all levels in the organisation and evidence of this was gathered from the participants' accounts of their conversations with the members of the national team. In a number of participants' accounts regarding the support provided by the national team and the Health Check programme's guidance document. There was an emphasis on activities that would enable them to demonstrate what they were achieving. This included routinely reviewing programme data which had been collected and put into a format that illustrated that the programme was on track to meet targets set by the DH and the SHA. In their view, it was the participants ability to meet targets that was being judged, therefore this justified why they needed this information to illustrate their performance.

*"So I suppose it was continually being evaluated to see if it met the guidance if it wasn't it was changed. So we've made several changes over the past since 2009. It's not radically changed because fortunately we were pretty accurate in our assessment of what they wanted but er but we have had to make some changes"(PHM4).*

An extreme example of tailoring is the downgrading of an evaluation, as illustrated in an account of one participant, highlighting their reluctance to present a process as an evaluation. During her interview, one of the senior managers (PHM6), who was a member of the Health Check regional group described an evaluation she had carried out to examine what impact the Health Check was having locally. The researcher was given a copy of the report to examine and observed that the final document was not called an "evaluation" but was called a "review". The researcher pursued this with PHM6, asking her why it was not labelled as an evaluation, as this was she had described what she had done an evaluation. She explained that the consultant who had requested that she do an evaluation told her that once it was completed that it should be titled a review instead of an evaluation.

Another form of tailoring was to discredit a report or data if the results were not as expected or were not required. Participants were observed to discredit or be critical of findings in

the final report of evaluations that were externally done. This was illustrated by participants either being unhappy with the source of the data, disagreeing with the way the data was derived, or voicing reservations about the interpretations of findings presented in a report. This extract from a conversation with one of the managers, as he explains the potential issues with the interpretation of others' findings demonstrates this:

*"Whereas somebody else might give you a big detailed report about Mr X and Mrs Y who did this this and this and really benefited and it's changed their lives and they'd done they'd gone on to do this that and the other and you might, you know, read that and think that's amazing but that's how they've reported it to you but what's to say that those other hundred people didn't also benefit in that way but it's just all you've got is a number so you don't know that so what I'm saying is it's what people tell you, how they've ... yeah (PHM2).*

## **7.7 Avoiding responsibility**

Responsibility emerged as a core category that provided an understanding of the participants' level of engagement with evaluation as a process. It became apparent from the themes that a number of strategies were being used to avoid the responsibility to formally evaluate programmes. In particular, participants who due to their professional status, evaluation knowledge and expertise should have had an active role in initiating and supporting the process, by their own admission avoided engaging with or initiating a formal evaluation. Designating the responsibility to evaluate a programme was determined by whether there was a need to respond to external demands, provide information that can throw "light on the programme" or deliver personal gain. The trigger for engagement or follow through with a reason to comply depended on which needs would be fulfilled. In most examples, the need was to secure funding or to demonstrate that a programme is liked by the clinical staff or by patients.

Where the responsibility for evaluation should lie was a subject that was raised in many of the conversations with participants. All participants were adamant that there was an expectation that the programme would be evaluated, and that someone else or another department should be doing it. Every participant, in an initial discussion about responsibility, said that evaluation was the responsibility of someone else or it was the remit of another group or organisation. However,



when asked to expand on this point, all participants did acknowledge that they knew they had a responsibility to ensure that programmes they were involved in implementing and managing were evaluated. When asked directly if they were responsible for ensuring that this was done, participants tended to give reasons for why they were not able to deliver on their responsibility to evaluate the programme themselves.

*"I suppose if you're looking for an individual who is responsible, who are, the lead is for that project should be responsible or that lead is delegated to someone on the project group who's doing it, to be responsible for evaluation, but someone should carry that label of responsibility" (PHL1)*

The only time that participants accepted the responsibility of evaluating a programme was when it there would be obvious personal gain or recognition, and was determined by a desire to showcase their role in getting the programme up and running successfully. One of the Health Improvement managers described why she had decided to evaluate a programme, her reasons were that it was her responsibility to evaluate a programme she was asked to deliver. She wanted to be able to show her manager what she had been doing and the evaluation would justify her involvement in the project. Others noted a similar sense of personal responsibility to evaluate a programme. Another of the health improvement managers explained that she had never been asked to evaluate programmes she was delivering but felt that for one programme in particular that she had developed and delivered, it was her responsibility to evaluate the programme. This came across as a particularly personal decision to proceed with an evaluation of a programme.

Participants who were public health consultants all acknowledged that they were responsible for evaluating the programme they were leading. While there was recognition of a collective responsibility in taking on the task to evaluate, when asked about their assignment of responsibilities with regard to the evaluation there was little evidence shown that this translated into personal acceptance that they as the senior members of the group were fully engaged with the process. When asked specifically about their responsibility concerning evaluating the Health Check programme, they were not clear about who should be given the task to evaluate the programme.

While participants expressed that it would be "procedurally and morally wrong" not to evaluate programmes that they were implementing, they also acknowledged it was expectation

that it would be done, they were not necessarily taking on the responsibility to evaluate. In many examples, the participants did not actually know who was responsible for evaluation.

*"It was never made particularly clear who should be responsible for evaluating the programme" (CM3).*

In addition to the lack of clarity about the personnel responsible for evaluating the programme, there was a reluctance to take on the responsibility to act on the findings of an evaluation. Participants acknowledged that it was essential to evaluate the programmes they were implementing in order to generate meaningful information that would contribute to their understanding of the impact of a programme. However, as one participant explained, the responsibility to evaluate tends to be accompanied with the responsibility to act on the information produced. He pointed out that nobody wanted to have to take on that kind of responsibility, as decisions made may not be popular.

*"...if we evaluated it locally and said it doesn't work, well so what we might think it doesn't work the GPs already think it doesn't work what are we going to do are we going to write to David Nicholson sorry David, sorry Jeremy we don't want to do this, here your programme doesn't work, no we're not, ...because nobody's going to stand up and say we're going to die in a ditch, ... so is there much point evaluating it locally" (CM4).*

Other participants also reflected this reluctance to act on evaluation findings and reflected on how this influenced their position in not assuming the responsibility to formally evaluate a programme. This was most apparent with the Health Check programme.

*"And I think that's why there's probably a reluctance to evaluate in public health because an evaluation generally doesn't show good things because of the ways it's traditionally thought about" (PHRM).*

A set of strategies that emerged that were aspects of avoiding responsibility were categorised as excusing and deferring. These were the various tactics that participants engaged with to justifiably avoid the responsibility of initiating or supporting an evaluation of a programme. Also to avoid engaging with the actual process of formally evaluating a programme and avoiding being associated with any process or activity that could be deemed as a formal evaluation that would generate critical or negative information.

Strategies such as excusing and deferring tended to be ones that were inactive or passive in nature. In fact, their strategies around refusing to accept responsibility were unlike actions such as pre-empting and tailoring, which tended to be proactive in nature and resulted in some form of outcome or output.

#### **7.7.1 Excusing**

The theme excusing included reasons for not taking on the responsibility for initiating or supporting evaluating the health check programme, as well as the reasoning behind non-engagement with evaluations to assess the impact of the programme.

The subject of the responsibility for evaluating the programme was specially raised with the participants who were public health consultants as it was expected due to their employment status and training they would have the skills and capabilities to initiate and carry out an evaluation of the programme. They did all acknowledge that they did have the responsibility for ensuring the programme was evaluated. However, this tended to be followed by a number of explanations as to why it was not possible for them to do it. Excuses as to why it was difficult to act on their responsibility, included the lack of skills within the organisation to undertake evaluations. The lack of skills and experience of doing evaluation within the organisation was given as an excuse by some participants as a reason for why evaluation was not being done. This was in contradiction with accounts provided by participants who were public health trained, in which they described their experience of designing and carrying out evaluation for professional accreditation. These accounts illustrated that there were indeed individuals within the organisation who had the skills and experience to carry out robust evaluation. They expressed concerned that either they or the members of their team lacked the required skills. The researcher enquired about the role of public health specialists in the team, asking if they were available to support carrying out evaluations. PHL3 explained:

*“Yeah one of my specialist registrars was erm interested in looking at evaluating the programme and actually wrote a protocol for her Masters dissertation but when we actually looked at the scope of that, it actually became rapidly clear that she would need to focus in a particular area rather than looking at the whole and actually we had intended it to look at the whole situation but actually it ended up very focused on smoking cessation and the referrals to stop smoking services” (PHL3)*

Another excuse that was given was the lack of official instructions or agreements to explain how or when an evaluation of the Health Check programme should be done. One of the participants explained there was little information provided for anyone to evaluate the programme. When asked why they had not done it, the participant replied:

*“leadership failing on all levels when it comes to evaluation” (CM4)*

The importance of the emphasis on implementing the programme before thinking about an evaluation was also expressed by PHL3. PHL3 explained that when she initially was involved in getting the programme up and running, she did think about how the programme would or could be evaluated. However, she remained focused on getting everything in place first. There was an acknowledgement that evaluating the programme could not be dismissed and that this needed to be considered, but this would not happen at the expense of focusing on getting the programme fully in place.

Participants explained that there were a number of organisational and professional expectations and obligations that needed to be fulfilled to ensure that the Health Check programme achieved its objectives which made it difficult to evaluate the programme. Various organisations and groups were primarily involved in the delivery aspects of the programme. Each of groups contributed to aspects of planning, implementing, managing and monitoring the Health Check programme and was expected to contribute to evaluation of the programme. At the regional level it was expected that the PCTs would be evaluating the programme explained the PHRM1.

*"PCTs are expected to evaluate the programmes, And we do request reports that are about evaluation of programmes and progress on programmes" (PHRM1)*

However within the health check task group no member of the group had expressed that they were responsible for evaluating the programme. Instead, they provided explanations as to why they were not responsible evaluating the programme.

*"we wouldn't be evaluating the health check programme because that's a public health programme" (CM2)*

The main reason for considering that evaluation was a task for public health professionals was that, in the view of the commissioning member of the group, it was a public health programme therefore they were expected to be taking on the responsibility of evaluating.

*"we will ensure or help to ensure practices are delivering the programme but in terms of evaluating the programme, because it's a public health commissioned programme we wouldn't get involved ...(CM3)*

According to the participants who were public health professionals, the Health Check programme was a national programme. It was their view that the members of the national team were in a better position to carry out a national evaluation of the programme.

*"I think but um but you're right no one has managed the data and I would be quite happy if the national evaluation wants to use our data. I'm more than happy with that (PHL1)*

There was a dominant view that it was not made clear who was responsible for evaluating the programme.

*"I mean I've been working here just under three years and come from a completely different environment and it wasn't openly apparent who did what.... and you know it was all a bit mixed" (PHM5)*

Reasons voiced for not evaluating the programme ranged from the practical to the theoretical. The practical reasons given were lack of time, money, skills and support to do evaluation or perceived difficulty because of the type of programme. However, when pressed to explain more about these, participants' answers became more of an excuse or justification instead of a reason or cause for not doing evaluation. The theoretical reasons given were largely to do with the difficulties they faced with applying the principles of evaluation. The programme itself and the related policies was not perceived as being well-thought out and flawed due to the national programme team's continual changes and additions to programme structure and delivery.

The desire to avoid being associated with the initiation of a formal evaluation was revealed in the rare example given in which a formal evaluation was initiated and conducted, but there was still an avoidance of calling it an evaluation. This theme reflected some of the concerns of being associated with formal evaluation to the extent that there was a reluctance to take on the responsibility of ensuring that they were conducted in the first place. There were a number of incidences when participants gave a description of a process or activity they had either undertaken or planned. When it was questioned as to why it had not been considered as being an evaluation, they explained that calling it an "evaluation" could open things up to scrutiny.

When asked about their own evaluation activities, participants preceded the answer by informing the researcher that they do not own the responsibility for evaluation. The participants did refer to their position in the organisation and the position of others in terms of their NHS employment band or grade to indicate their level of responsibility or their level of expertise in relation to evaluation. As far as the CVD task group members were concerned, they were mainly responsible for ensuring that systems were in place and were functioning to capture the appropriate data and that appropriate reporting mechanisms were in place to retrieve the necessary data when required.

It became apparent that the expectation to evaluate was associated with the ownership of the programme. This was integral to how responsibility to evaluate was viewed. Ownership and control were additional factors that were associated with reasons for not taking on the responsibility of evaluating the programme. Ownership of the programme and the ability to exert control over the process and outcomes were presented as a reason for either taking or not taking on the responsibility to conduct or carry out an evaluation. With regards to Health Check programme, a number of participants did not have a sense of local ownership of the programme. PHM4 went as far as saying that the programme was "foisted" on them. She felt that there was

no sense of local ownership and that decisions made locally would ultimately have no impact on the programme's outcome. The point about ownership was expanded on by CM4 who explained that it was not clear who should be responsible locally for evaluating a national programme. For him, it was easier to evaluate a programme that is locally developed, as there was then a sense of a sense of ownership and greater ability to achieve 'buy in' from colleagues. He went on to explain the importance of being involved in all aspects of the programme, starting from the beginning, so that the reasons for doing an evaluation are agreed and it is understood to be in everyone's interest. In the example he provided, the aim of doing an evaluation was to provide information to ensure funding was secured. It was his responsibility to ensure that programmes and services were maintained. In his view, there was no benefit in putting aside the time and effort to evaluate a national programme at a local level when it was not possible to act on the results.

In the examples provided by participants in which an evaluation had actually been done, these tended to be associated with projects or pilot programmes that were either local in origin or were short-term. Importantly, they were ones in which participants explained they felt they had some control over the decisions to continue or discontinue the programme. One clear reason expressed for not doing evaluation was the concern that it might show something was not working or as the regional manager explained:

*"I think there's an aversion to doing the evaluation because if it shows something that people don't like..."(PHRM1)*

Another strategy was to avoid calling the result of a process that was to describe an evaluation as review or monitoring. This was illustrated by PHL3 who started by describing the evaluation of the pilot of health check programme that she implemented as an evaluation. PHL3 ended the description by explaining that even though evaluation methods were used in the end it was more of a review to understand the processes to support the implementation of the programme.

*"I'd say the pilot was monitored and then lessons were learnt and applied to so looking at the monitoring the activity monitoring from the pilot activity and taking the learning from that and actually making improvements"(PHL3)*

Importantly according to her the process helped them to understand what data systems needed to be established and what type of data needed to be collected. This justified it being describing as a review used as it was seen as more acceptable because it was perceived as a way to provide information about how to do things better, not to determine the impact for a programme or to establish if it were worth continuing.

### **7.7.2 Deferring**

Strategies such as deferring suggested that whilst there was there was an underlying desire to evaluate programmes, this did not result in the necessary actions required to initiate or conduct an evaluation. This theme indicated that participants were aware of their responsibility to evaluating programmes they were involved in delivering, but were in fact deferring the task. Deferring was illustrated in a number of ways, primarily when participants described their intention to do an evaluation. Participants gave detailed accounts of what they had planned or were planning to do, and then would explain why this needed to be delayed.

The overriding concern for participants was to get the programme implemented, and this was reflected in a number of participants' accounts expressing the view that their priority was to do what they could to ensure that the programme was implemented. While there was an expectation that an evaluation of the programme would eventually take place, it was the delivery of the programme that took priority according the participants.

*"I say you have to map out the steps that you're going to do...to get the programme going first, so there's no point in evaluating a programme 'til you're happy really that the programme's in place". (PHL1)*



All participants expressed an awareness of the importance of evaluating programmes they were implementing. They did consider it as part of their professional duty, as well as being a moral obligation. This expectation of an evaluation role was apparent, as all participants gave examples of programmes they were intending to evaluate. This was expressed as either as an expectation that some person or team would carry out a full evaluation of the programme at some stage in the future, or that they had plans to do so themselves when they got the chance. However, what the participants rarely made clear was what form the evaluation would take, and when pressed, they explained that it simply needed to be an activity or a process that would demonstrate if the programme was having an impact.

The CVD task group, for example, had already developed an evaluation strategy that was to be used to support the evaluation of the Health Check programme. The researcher uncovered this fact during one of the meetings and asked if there was a copy, as there was not one available in the Sharepoint. It was explained that there was a copy somewhere. When asked why the strategy was not being put into action and used to support the evaluation of the programme, it was explained the programme needed to be in place for a few more years before it could be properly evaluated. The strategy was never operationalised as the person who had written the document had moved on and no one else had taken on the responsibility.

The intention to evaluate the programme was expressed by the participants. This was not accompanied an understanding who would be responsible for doing an evaluation.

*“We certainly discussed how to evaluate right from the start as we were setting out the systems for carrying out the health check programme .... I think yeah I think there were a lot there were a number of people involved and actually recalling who was responsible for what is quite a difficult one”(PHL3).*

According to participants the fact that programme implementation was a dynamic process, meant it was subject to changes, this was noted as a factor reasons for delaying when an evaluation could take place. Participants talked about the difficulties of delivering the Health Check programme within the climate of constant change regarding what the programme was supposed to achieve. PHL2 and PM7 explained that the programme requirements kept changing consequently and that they were constantly having to change things to keep up. All of this had an impact on their ability to carry out an evaluation of the programme. Therefore, the CVD team’s

evaluation strategy was put aside and was expected to be used when the national team and the DH were more certain about the programme's outcomes.

## **7.8 Demonstrating success.**

When further analysed, the themes illustrated that an integral aspect of evaluation in practice was the overriding desire to demonstrate success in some form. However, what constituted success was rarely defined, except in terms that it was associated with demonstrating "positive" results. The strategies and processes defined by participants all suggested that they were actively seeking to illustrate only the positive aspects of what the programme and they were achieving. They were willing to ignore any negative outcomes of the programme. Their aim was to provide the necessary information to enable validation for the programme's continued implementation and funding.

*"part of the process is you have to evaluate what's being done, prove it's success and then you get the next lot of money. If you can't if you can't prove it's successful you don't get the next lot of money" (PHRM)*

The achievement of nationally derived targets was commonly viewed as an indicator of success.

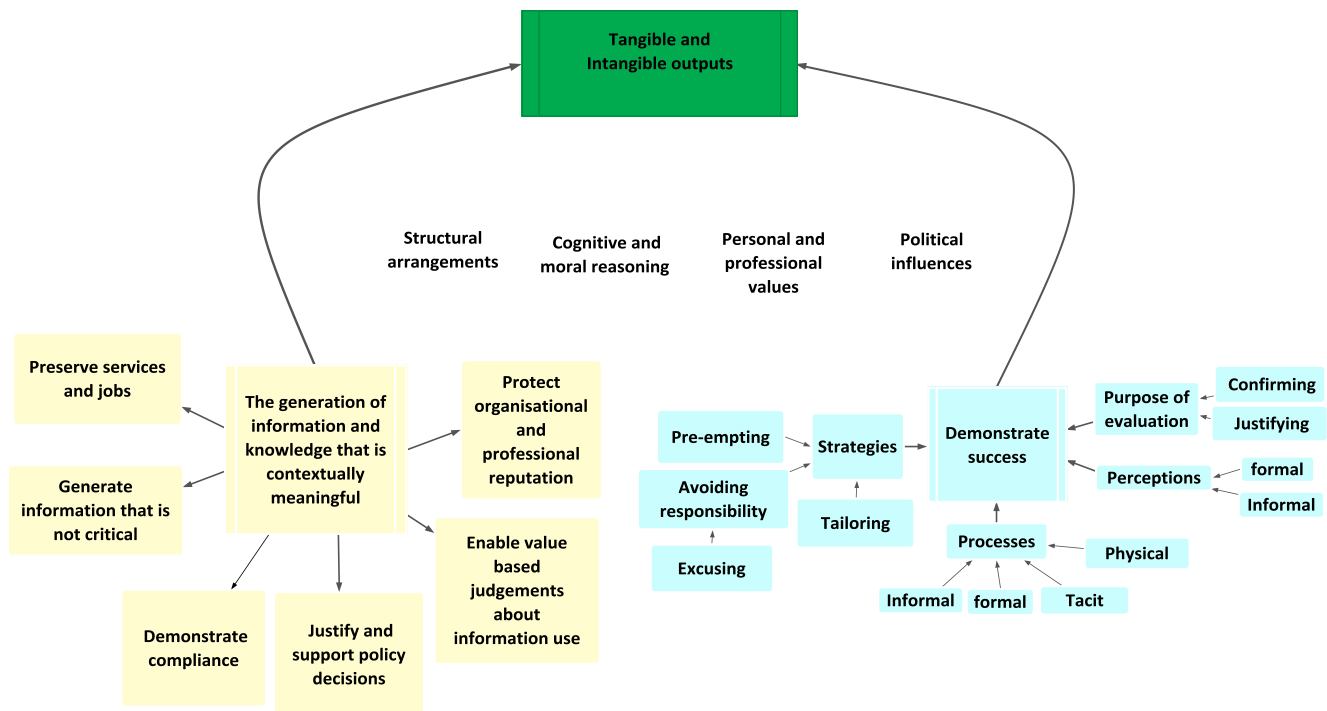
*"we have to report monthly to the SHA that's a very it's whether you class it as evaluating, because you're evaluating the success of meeting your targets" (PHM3).*

The need to show success was a factor expressed in different ways by the participants, however the underlying message was that they did not want to do a form of evaluation that provided information or that can knowingly be easily dismissed or discredited. An overriding concern was the dangers of having to reveal damaging information. This was reflected in the conversation with a senior manager, who explained

that the annual report was a key document, as it was able to show others how well the programme was doing. In practice, the criteria for determining success revolved around a number of operational factors, including the processes and systems that were put in place, how they were received, and how they were delivered.

Figure 13 is a conceptual map that was developed to illustrate the relationship between the themes were conceptualised and led to the notion that demonstrating success was a major driver for evaluation in practice as demonstrated by strategies employed by participants to produce output that were could be strategically used. This will be discussed in more detail in 8.3 why this conclusion was reached will be discussed in more detail.

**Figure 13: Conceptual Map**



## 7.9 Summary

Overall, the analysis indicated that there was an overriding desire to show or demonstrate success, and that it was this desire that dictated the nature of evaluation in practice, both in the way it was perceived and how it was carried out. The themes presented in the previous chapter contributed to this notion that demonstrating success was a major driver for evaluation in practice. Factors such as having many organisations, as well as national and local teams involved in the implementation and delivery of the programme resulted in blurred lines of accountability and unclear lines of responsibilities. This ultimately led to no one being willing to take on the responsibility of robustly evaluating the programme. The implied expectation in various guidance and programme documents that the Health Check programme would be evaluated was not accompanied by official instructions or agreements. With no formal arrangements in place, participants had the freedom to determine the format an evaluation of the programme should take evaluation.

In practice, evaluation was happening in a form that did not meet the formal definition of evaluation that was offered. Instead, in practice it was a more fluid, dynamic process in which a range of physical and tacit approaches were used. The analysis demonstrated that participants were primarily engaged in activities that focused on collecting and managing data, to produce both tangible and intangible outputs that were strategically used to demonstrate success. This indicated that the aim of evaluation, according to the participants, was to fulfil a confirmatory function.

## Section three

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Section three contains the discussion that includes an overview of the main findings, highlighting the original contribution this study makes to our understanding of how evaluation is perceived and carried out in practice. The outcomes of the second level of analysis to provide an explanation of why evaluation in practice is carried out the way it is will presentation and discussed. This will then be followed by a discussion on the implications of the study findings for future policy and practice. The strengths and limitations of the study, as well as reflective account of the researcher's perspective on undertaking this study will be discussed. This section will end with a concluding summary.

## Chapter Eight

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### 8 Discussion

#### 8.1 Introduction

The aim of the study was to get a clearer understanding of how evaluation was perceived and conducted in practice by a specific group of health professionals involved in the day-to-day activities of implementing and delivering a national programme at a local level. The key original findings from this study in the context of relevant theoretical literature will be discussed, starting with a summary of the key finding. After which evaluation in practice will be discussed in the context of theories of knowledge to provide an understanding of what was happening with evaluation in practice. This will be followed by a discussion of the implications of these findings on policy and practice. The chapter will end with, a discussion on the strengths and limitations of the study, the researchers reflection of key aspects of the research process and a conclusion.

#### 8.2 Summary of Key findings

The findings from this study have contributed to a much-improved understanding of evaluation in practice. In particular, the emergent themes enhance understanding of the ways in which different types of knowledge are formulated by various forms of evaluation and the manner in which health professionals make strategic use of this knowledge to meet personal, professional and organisational obligations. The findings of study provides an understanding that evaluation in practice is a process that aims to produce outputs this are primarily positive, so as not to compromise services, organisational reputation and policy decisions. The themes from this study suggest that participants did have a broad understanding of evaluation and were engaged in strategies to demonstrate that they were meeting the organisational requirements and providing information that was contextually meaningful.

The definitions provided by the participants indicated that they did have an understanding of evaluation principles and methods. Their understanding was combined with experience and specialist knowledge, suggesting that they did have the capabilities and

experience to carry out robust evaluation. However these skills to undertake robust evaluations of ongoing public health programmes were not being employed as might be expected.

Participants largely categorised evaluation processes as both formal and informal. Informal evaluation was described as the on-going assessment of programme activities and performance. This delineation of formal and informal evaluation was also related to the outputs of evaluation processes, which were either tangible or intangible in nature. Informal evaluation emerged as an integral aspect of the everyday activity of implementing and delivering the Health Check programme locally, representing evaluation in practice. Informal evaluation was portrayed as an integral part of the everyday activities associated with delivering a programme. It was a form of evaluation underpinned by intuition and a set of values and beliefs. This resulted in the production of non-analytical information that was largely practical and descriptive in nature. Formal evaluation on the other hand was perceived as a structured, systematic process, underpinned by scientific principles that provided reliable unbiased information and empirical knowledge. These formal evaluations acted as a visible demonstration of compliance with national policy objectives, standards and targets.

The study's participant's perceived evaluation at a local level to be concerned with activities that assessed and monitored programme delivery, and therefore provided information that was descriptive in nature. Participants focused their efforts on gathering and providing information that described the operational aspects of the programme, as there was little incentive or support to do forms of evaluation that produced different types of information which could be used critically to assess the impact of a programme.

The limited number of references to evaluation found in the programme's national policy and guidance documents reinforced participants' perceptions that evaluation of the Health Check programme was not a priority. This was also evident from the nature of the guidance and support provided by the national team within DH, in which evaluation was referred to only once in the context of reducing health inequalities. In addition, the references to evaluation in the local guidance and PCT documents were in the form of direct instructions to monitor and performance manage the programme delivery.

It was observed that there was sufficient data available to evaluate the impact and cost effectiveness of the programme. However, public health practitioners did not perceive it to be their role to use the information they were collecting to carry out such a task. Instead, they focused their efforts on using the data to generate information for practical purposes, to support operational decisions that would ensure the programme's continuation.

The analysis illustrated that there was a clear understanding of theories and principles of evaluation but there was no attempt to apply the theoretical understandings to the programmes that were being delivered locally. It became apparent that evaluation in practice was strongly influenced by a range of contextual factors that prevented evaluation in a format that provide a critical examination of the programme for a full understanding of its impact.

In the next sections of the discussion, these findings will be discussed further in the context of relevant literature. The claim that evaluation in practice is influenced by organisational, professional and political desires to show positive outcomes, and that there is complicity at all levels allowing this to happen will be explored.

### **8.3 Understanding evaluation in practice**

This study's methodology of using a grounded theory approach led the researcher to first undertake an initial level of analysis, which has been presented in the results section (Chapters 4 to 7 above). In this section of the discussion a synthesis of these findings in context of the literature will be presented, offering a deeper analysis of evaluation in practice. The findings will be discussed in the context of three separate but interrelated theories of knowledge. This body of literature was deemed to be relevant because the themes that emerged from the research indicated that a key purpose of evaluation in practice is to provide information in a format that enable positive results to be demonstrated.

Firstly, the literature on the “data-information-knowledge-wisdom” hierarchy (Ackoff 1989) provides an understanding of mechanisms used to transform data into knowledge. Secondly, theories on tacit knowledge (Polanyi 1962) are used to explain the different types of knowledge that individuals draw on in certain situations and how these are used as a form of evaluation. Finally, literature on theories about the social functions of ignorance. Moore and Tumin (1949) Smithson (1993) theories offer another set of insights about the influence of contextual factors on the formation and use of information that results in ignorance instead of knowledge. Together, these theories help to explain the different aspects of evaluation in practice that emerged.

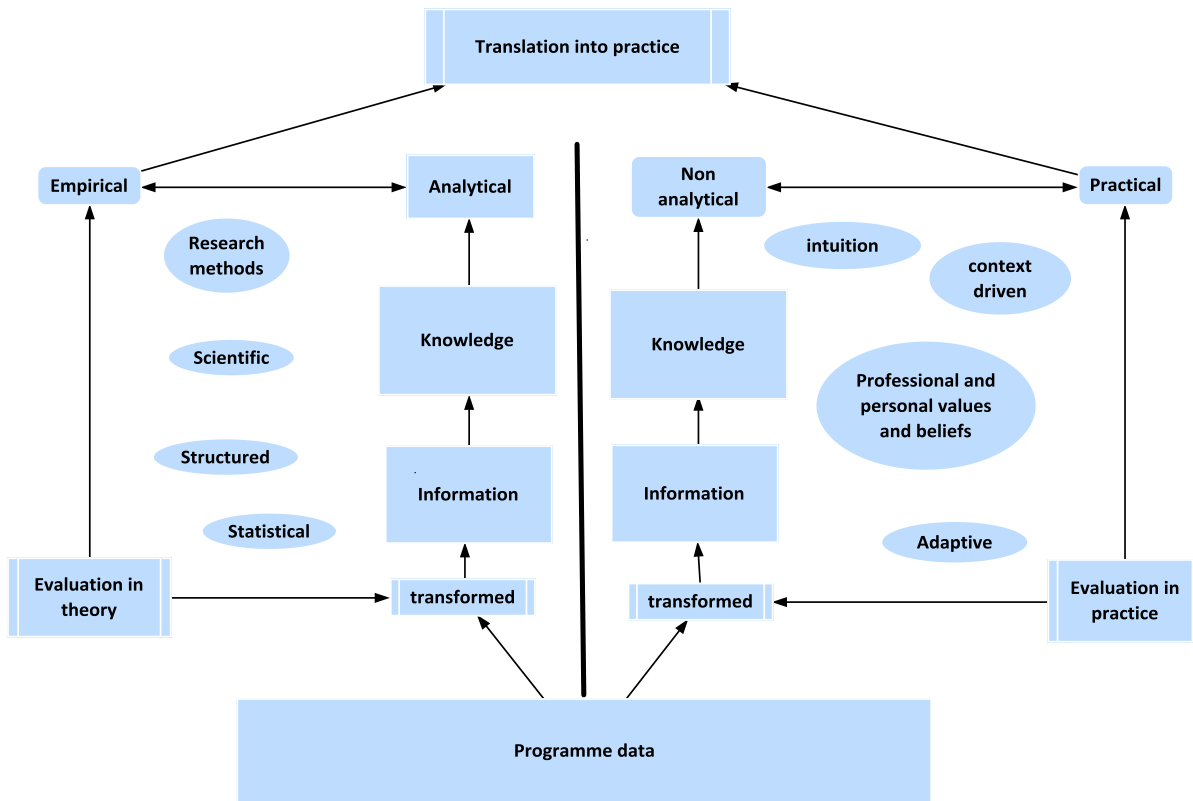


### **8.3.1 The different forms of knowledge formulated by evaluation in practice**

The varied interpretations of evaluation presented by participants indicated they had a broad understanding of the concepts and principles of evaluation. Importantly, the main aim of evaluation, from their perspective, was to generate information and knowledge that was contextually meaningful. The findings demonstrated that participants were aware that data treated in particular ways provided different types of understanding about a programme. This suggested that one of the aims of evaluation was to transform data into different forms of information and knowledge. The way participants clearly delineated evaluation as both formal and informal, both in terms of a concept and a process, was a further indication that their notions about evaluation were influenced by different sets of values, principles and contextual factors. These factors were organisational, professional and political in nature.

Figure 12 below exemplifies the different features of these two distinct forms of evaluation. The findings illustrated that not only is there a clear difference between evaluation in theory and in practice, but that this difference is understood by the participants. Formal evaluation was perceived as a structured, systematic process underpinned by scientific principles that provides reliable unbiased information resulting in empirical knowledge. On the other hand, informal evaluation was portrayed as an integral part of the everyday activities associated with delivering a programme. Informal evaluation was underpinned by intuition, professional and personal values and beliefs, and resulted in the production of non-analytical information that was largely practical and descriptive in nature

**Figure 14: Evaluation and Knowledge Framework**



This diagram (figure 14) shows how formal and informal knowledge generated by the different forms of evaluation was translated and used in practice. This delineation of evaluation suggests that participants were aware of the different knowledge orientations of these two forms of evaluation. This was reflected in the perception that formal evaluation approaches are associated with academic rigour, meaning that the resulting information is objective and hence more reliable. Informal evaluation, on the other hand, was associated with operational activities. It was ongoing and unplanned, therefore more subjective and unreliable.

These differences also suggest that participants' understanding of evaluation was shaped by two differing paradigms, one in which evaluation was governed by scientific principles and the other governed by professional and personal values. Information from evaluations that were scientific in nature is given higher status because it had been derived from a process that protects against subjectivity. In contrast, the paradigm that governed ongoing evaluation was subjective in nature, and was therefore less likely to be considered as reliable. The outcomes were practical

knowledge, which was descriptive as opposed to analytical, and supported the operational aspect of programme delivery.

Furthermore, the delineation of formal and informal evaluation by the participants illustrated the differences in the perceived understanding of evaluation to what was actually happening in practice. In particular, the principles and methods that were applied to formally evaluate programmes in practice tended not to resemble how evaluation in theory was represented. It became apparent that the treatment and management of data were central to the participants' activities. In practice, formal evaluation in fact became a means to formalise knowledge into tangible formats. The outputs of the process of evaluation are discussed more detail in the section 8.2.3, as this relates to how information is formulated and used.

Ackoff's (1989) framework provides an explanation of the process involved to formulate knowledge and wisdom. It gives an overview of the procedures that participants were using to make sense of the data they were collecting. Ackoff (1998) defines data as a raw fact, explaining that information is data that has been given a value, and knowledge is the wider interpretation of this information. The features of formal and informal evaluation illustrate how the use of different value systems actually underpins the process of transforming data into information. This then leads to different forms of knowledge outputs.

This theory offers an explanation for why the collection and storage of data was important to participants. This was their acknowledgement of the essential role of data in the production of information. The process of producing knowledge occurs through a number of reasoning processes that determine how data is transformed into information (Ackoff 1989). Ackoff suggests that the processes involved in transforming data into information are not value-free. This was evident from the participants' activities. For example, making sense of the data through conversations and reasoning activities suggests that these formed part of the process of formulating information. Furthermore, Ackoff (1989) suggests that the reasoning processes used to transform raw data into information ultimately determines what form of knowledge is produced. However, in the context of this study, the end products of this process were not as depicted in Ackoff's (1989) hierarchy, in which the knowledge created provides a higher level of understanding or wisdom. In practice, the information generated did not provide a higher level of understanding in a tangible format. What was actually happening to the programme data in terms of how it was being treated and managed was in effect the starting point for the production of information and its subsequent use. Suggesting that this important step in the evaluating process in practice.

Participants' delineation of evaluation into formal and informal shared many of the features of Polanyi's (1962) concepts of tacit and explicit knowledge, indicating that another aspect of evaluation was related to the different forms of knowledge drawn on to support the formulation of knowledge. According to the participants, evaluation was the tacit knowledge that was unexplained. This was reflected in several instances, in which participants were unable to articulate and fully explain their understanding of what was occurring in practice. The reasoning approaches used to assess that data were ones that ensured programme delivery was successful. It was found that a feature of evaluation was the use of a combination of reasoning and physical processes that produced outputs that were tangible and intangible in nature. These provided an understanding of how programme data, knowledge, and intelligence gained through conversations and feedback was being used strategically.

A key aspect of Polanyi's (1962) theories of knowledge is the distinction between tacit and explicit knowledge, and how these are both formed and used by individuals. The fact that participants favoured tacit knowledge and tacit approaches illustrated that a key feature of evaluation in practice was the use of personal knowledge that was intuitive and unexplained. Participants needed to be adaptive and responsive – evaluation in practice involved being able to respond to changes in policy, and programme aims and objectives. In this context, personal knowledge became an asset. The main objective for participants was to ensure that the information they presented was in line with current political and organisational requirements. Therefore the value judgements they made determined which output would be beneficial and meaningful to support programme delivery and implementation in this context.

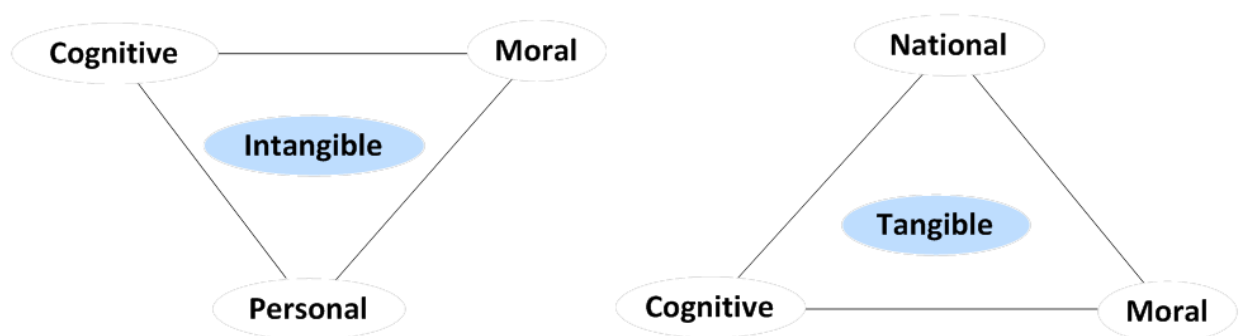
In the case of the Health Check programme, the intended output often dictated what shape knowledge would take. Evaluation emerged as being an integral part of the process of transforming data into information and then into knowledge. The ways that information was interpreted and used as knowledge was another aspect of evaluation that was key to the process of information generation, and as outlined previously, is contextual. This is better explained by the theories of ignorance and tacit knowledge. These help to explain the factors that lead to the selective use of information and knowledge, and the role of reasoning systems in the evaluation process. Importantly, these theories will help to uncover why robust evaluations that provide critical findings were not instigated or supported in practice.

### 8.3.2 Types of output

The participants acknowledged that evaluation was determined by the context in which it was being considered, and that this in turn influenced how data was treated. The information from a formal evaluation, in which a recognised framework was used, was perceived as more valid than information generated from an informal evaluation in which the process was unstructured. It was also established that the end product of an evaluation varied according to what information and knowledge was required. This section analyses evaluation in practice, in the context of the production of both tangible and intangible outputs, building on the discussion in the previous section about the evaluation as a knowledge formulation process.

A key aspect of the process of evaluation identified by participants was the decisions made about the presentation and sharing of information and knowledge. The way data was valued and then presented as meaningful information was in itself a form of evaluation. This form of deliberation took into account factors at several levels, from personal to national level. These determined how information about programmes delivered locally should be presented in reports or used orally during meetings to support decision-making. This resulted in what can be described as a strategic use of data and information to produce outputs that were both tangible and intangible.

**Figure 15: Tangible and intangible outputs**



Polanyi's (1969) theories of tacit and explicit knowledge help to explain the importance of the different outputs generated when knowledge and information is formalised and shared by individuals. Explicit knowledge, according to Polanyi, is knowledge generated through a process of codification of data. It is a form of knowledge that can be formalised and shared, and formulated

into something tangible. This format was used in the Heath Check programme to support decisions about the data and its use.

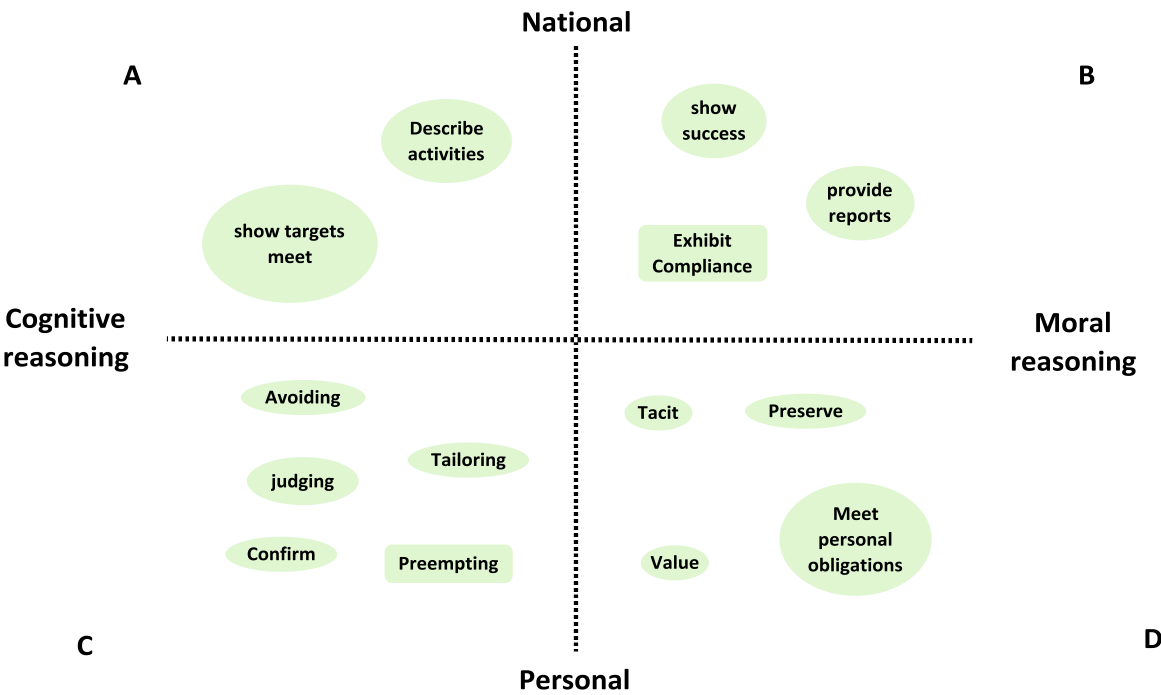
In fact, both explicit and tacit knowledge were commonly in use, and participants were using both of these forms of knowledge to make sense of the programme and its delivery. Informal evaluation tended to be primarily tacit in nature, and participants found it difficult to explain how they knew what they knew. However, there remained aspects of informal evaluation with similar characteristics to explicit knowledge, including the fact that this was a form of knowledge gained from experience and training. The difference between the two tended to be in the nature of the outputs produced – the outputs of informal evaluation tended to be intangible, in other words reliant on tacit knowledge, whereas those from formal evaluation tended to be more tangible or explicit.

At the same time, the findings indicate that not all explicit knowledge was represented as tangible outputs. An important part of formal evaluation, according to the participants, was both the codification of data and the use of local intelligence to form both tangible and intangible outputs. There were times when this knowledge remained in an intangible format, as embedded knowledge that was shared and used amongst the participants and not written down. It was these intangible outputs that were an important aspect of evaluation in practice. It allowed participants to use their skills and abilities to gain an understanding of the programme without putting services or organisational or professional reputation at risk. Exploiting this level of understanding was important as this enabled participants to determine what form an evaluation should take, while recognising that it would not present that level of understanding in a tangible format. In the case of the task group, a tangible output was any format that contained information that was written down and presented externally to other professional groups and organisations. This included information about the programme activities that were included in the minutes, the monthly data and the annual report presented to the PCT board.

In the Health Check programme, the outputs were influenced by contextual factors that determined the interpretation and use of information. In Figure 14, the quadrants illustrate the variety of factors that influenced evaluation in practice from the national level to the personal level. These included the organisational, professional and personal factors that influenced how judgements were made in relation to the data, its interpretation and its representation. Together they illustrate, as Moore and Tumin (1949) suggest that contextual factors do influence the nature of information and knowledge. They also demonstrate how the reliance on reasoning

systems to ensure that resulting information and knowledge was appropriate such an important aspect of evaluation in practice.

**Figure 16: Conceptual Framework: Evaluation as a process of managing knowledge outputs.**



In the upper left (quadrant A), where cognitive reasoning is guiding decisions around the management of knowledge at the national level, evaluation outcomes are likely to be formal reporting on targets and formal evaluation reports. In the upper right quadrant, it is moral reasoning that is guiding decisions at the national level review reports, annual reports, and other written documents form the tangible outputs. In the lower left quadrant, cognitive reasoning is guiding decisions around the management of knowledge at the personal level, the key activities were codification of data and management of and the resulting output intangible. In the lower right (quadrant) where moral reasoning is driving decisions about the management of knowledge at the personal level, evaluation outputs are much less tangible. They consist of meeting content and group discussions, verbal reviews and informal sharing of learning. In practice, most activity was in Quadrant D, where staff actions were motivated less by expectations and more by a sense of obligation, hence their reliance on moral rather than cognitive reasoning. At the same time, they were operating within an institution that enabled the development of intangible outputs.

They were also working in a culture that was both success-driven and supportive of individual actions and social functions that were driven by ignorance, as opposed to knowledge.

A further key element of evaluation in practice was the reasoning processes that were used to assess and validate the data collected for the programme. This included information gained from conversations and feedback from colleagues and fellow participants. The interactions between the participants indicated that this was an important aspect of evaluation in practice, driven by the fact that they were working in an environment in which practical knowledge could be articulated (Polanyi 1962). This was illustrated by participants' interactions during meetings, in which a reliance on oral communication and focus on gaining feedback was deemed important for how information was interpreted and presented.

The importance of the nature of the relationship among professionals at local level was further demonstrated through the impact of the nature of the information that was provided to the national teams. This was reflected in the reports that were created for the national teams. In these reports the information provided was description with little analysis or interpretation. These reports contrasted with the detailed conversations at local level in which the resulting information had more context and meaning. In reality, this intangible information was the explicit knowledge that was shared and exchanged and not actually included in the reports or reviews.

These processes enabled participants to interpret data in order to meet their requirements for demonstrating success. Presenting, for example information on the achievement of targets. At the same time, they were able to make different sets of interpretations to gain a higher understanding of the programme, in the wider context, in order to support strategic decision-making. These multi-layered interpretations of data became the embedded knowledge that was shared and used by participants, in line with Polanyi's (1962) theories that highlight the distinction between tacit and explicit knowledge.

One form of knowledge produced provided an understanding of what was going on within the Health Check programme. This form of knowledge remained embedded, was shared, and was used to inform decision-making at the local level. It was the nearest to the form of knowledge described in Ackoff's hierarchy of knowledge. The other form of knowledge produced, in practice, was more in line with Moore and Tumin's (1949) concepts of knowledge as a form of ignorance. Contrary to Ackoff, Moore and Tumin (1949) suggest that in certain situations the knowledge produced does not offer a higher level of understanding. Instead, it is knowledge that provides an incomplete or unsatisfactory understanding, and is described as ignorance.



The participants' justification to continue with the Health Check programme whilst at the same time being critical about the ability of the programme to deliver what it was originally set out to do was a further indication of the duality in the interpretation and use of knowledge in practice. Their rationale was that it was better to have something in place that was good enough, than to have nothing at all. This adds to the notion that evaluation in practice was largely perceived as a mechanism to filter information or to provide validity information. The participants validated their decisions not to conduct forms of evaluation that would provide information that was critical of the programme because they felt that it was sufficient that they were providing members of the wider community with an opportunity to have contact with health professionals. This was considered a valid reason to continue delivering the programme. Their reluctance to conduct a robust evaluation was driven by their perception that it could provide unfavourable information in a format that had to be taken into account. In their view, this could ultimately jeopardise services. Their reluctance to take any action to understand if the programme was having an impact on reducing cardiovascular disease was linked to their "gut feeling" that an evaluation would not be able to show that the programme was not having such an impact. At worst, an evaluation had the potential to demonstrate that the programme was either ineffective in improving health outcomes or not cost-effective.

### **8.3.3 The social functions of evaluation protecting and preserving**

This section presents analysis about why evaluation in practice was perceived and carried out in the way it was. The different features of evaluation, in the context of implementing and managing the Health Check programme, provided an understanding of why professionals with the relevant skills, experience and professional autonomy did not apply their knowledge and skills, or exercise their professional autonomy to evaluate the programme. It was found that the organisational arrangements, structures and political factors were key elements that influenced how participants engaged with evaluation in practice. The political nature of the Health Check programme, for example, meant that there was limited support from national to local level for taking on the responsibility of either initiating or carrying out a robust evaluation. Importantly, it was revealed that there would be a reluctance to act on the results from a robust evaluation.

This reluctance was reflected in a number of ways, the lack of formal or informal reporting channels or arrangements to support local evaluations; the lack of formal and informal

communication channels to send findings from locally conducted evaluation to national teams; and the fact that each organisation involved in the delivery of the programme had their own reporting and monitoring arrangements in place. Together, these created an environment in which there were no clear lines of accountability throughout the system for evaluation. As suggested by the theories of the social function of ignorance (More and Tumin 1989, Smithson 1993), these are all features of an environment in which the production of knowledge that reflects what is really happening is not encouraged.

The analysis in this study illustrated that at one level, participants were engaged in activities to demonstrate that they were meeting their personal and professional duty to deliver a programme through the production of intangible outputs. On another level, they were engaging in activities to ensure that they were meeting organisational, professional and political requirements to show positive results by providing tangible outputs. What was happening in practice has a number of similarities with Moore and Tumin's theories about the various strategies that are employed by professionals to ensure that what they provide is incomplete knowledge or information that will not be damaging to the status quo. Moore and Tumin (1989) describe the type of knowledge formulated in this situation as ignorance, as it does not provide a full understanding of what is going on but tends to be distorted or misrepresented in some fashion.

In practice, the deliberations regarding decisions about the way that data should be produced were ones that Smithson (1993) identified information tends to be incomplete; there are deletions; or the information being used has many similarities with the theory that ignorance serves as a social function (Moore and Tumin, 1989). Documents labelled as evaluation were given high status because of their association with a process that provides empirical evidence. However, as Judge (cited in House of Common 2009) has pointed out, these outputs were mainly descriptive with little analytical information that could be used as evidence. The research uncovered that the intention was not to provide information to misinform, but to provide information that would not offer a full understanding of what was happening regarding programme delivery.

The participants were providing information that of a descriptive nature with little interpretation, rather than engaging in activities that resulted in information that had deletions or distortions. The participants' focus was on the collection and storage of a vast amount of programme data and a "comprehensive" set of data that would allow them to respond to requests to provide the necessary information to show successful outcomes. This level of

information in the annual and monthly reports and reviews ensured that participants did not include their interpretation or wider understanding. There was a widely held view that the information provided would be sufficient for policy-makers to further interpret if they wished.

Based on what was happening in practice it can be argued that what was being done was in line with Moore and Tumin's (1949) view of ignorance, where the primary function of evaluation was to preserve services and organisational reputation. It is their view that ignorance serves a number of functions including preservation of privileged position or the reinforcement of traditional values. Moore and Tumin (1989:p795) propose that ignorance in this context is an "active often positive element in operating structures and relation". They go on to explain that this is a process resulting in the preservation of either the institution or community. When the reputation and status of professionals are at stake, strategies are taken to ensure these are not put at risk. Professionals in these situations tend to comply with what is being requested in terms of producing the type of information that is required. They also benefit from the stability and the protection of the institution (Moore and Tumin 1949, Smithson 1993). The participants' behaviour and their treatment of data suggested an existence of a combination of political and organisational factors that created an environment which sanctions the production of information that does not reflect fully what is happening. This was reflected in participants' perception that there was a lack of organisational structures or support to enable evaluation. The vague instructions provided regarding evaluation in the programme documentation, combined with the lack of clear lines of accountability and responsibility, support the view that participants were working in an environment that allowed and enabled an informal approach to evaluation to dominate.

In practice, determining when tangible or intangible outputs were necessary involved making an assessment of the information and data available. This could include the collected programme data or other forms of information. These assessments involved taking the consequences of the resulting information into consideration. It was considered important not to provide data that would contradict any of the information that the SHA was providing to the national teams. This challenge actually enabled the task group to identify where extra effort was needed so that national targets could be met. The ability to achieve national and local targets was regarded as a sign that the programme was a success. This reactive approach was reflected in conversations during the monthly meetings and amongst the core task group regarding the format data should take when it was presented as information. Participants admitted that meeting the national and regional targets was not in itself an indication that the programme was successful, but that it was the information they needed to provide. This is also in line with the

theories of ignorance and constitutes the filtering of information and only presenting what is necessary (Smithson, 1993).

Overall, it emerged that it was considered to be both a collective and individual responsibility to ensure that organisations met their targets. This was justified as being more important than having an objective understanding of the programme's impact. The themes that emerged from this research, such as tailoring, avoiding, pre-empting and deferring, suggested that a core feature of evaluation was to provide information to serve a particular purpose. In the case of the Health Check programme the purpose was provide information to demonstrate achievement of national targets. It was noted, however, that the higher the political, organisational and individual investments associated with a programme's implementation and delivery, the more important the obligation to demonstrate the impact of a programme became.

#### **8.4 Implications for public health policy and practice**

The study was done during a period of significant change within the NHS, shortly before responsibility for public health programmes, including the Health Check programme, was transferred to local government organisations in April 2014. The findings therefore are a reflection of what was happening in the context of the PCT environment shortly before their abolition, and in the context of delivering the Health Check programme. The Health and Social Care Act 2012 placed an emphasis on measuring the outcomes of programmes, and there has been a reinvigorated interest in the development of a public health knowledge base to support and improve the delivery of services. This is reflected in Public Health England's new strategy to develop public health knowledge and information so that the commissioning and delivery of services is supported with the appropriate knowledge and evidence.

A key part of the role is to improve public health knowledge. PHE have recently published their knowledge and information strategy, which places an emphasis on the generation and utilisation of research findings.

The same public health team is still delivering the Health Check programme. They are now delivering the programme in the local authority, an organisation with a different set of value and norms to that the Primary Care Trust. This is being done in a system that has even more

complex arrangements, and with even more unclear reporting arrangements, than when it was being delivered within the PCT.

Political interest in the Health Check programme has grown even more and it has been strongly supported by national government policy-makers including government ministers. However, the programme tended to be criticised within the public health community as being a programme with no evidence to demonstrate is it effective or cost effective (Houser of Commons Health Committee 2014). It was highlighted by the recent Heath Select Committee report in 2014 as a programme being delivered with very little evidence available to show that it was having an impact. An implication of this is that there is in fact even more pressure to demonstrate positive outcomes and show that the programme is having some benefit.

The conceptualisation of knowledge within public health literature still appears therefore to be limited to knowledge as being a form of information. There were many examples in the public health policy literature in which references were made to the management of knowledge and the use of knowledge to develop public health programmes and to inform policy. Again there is very little reference made to evaluation. Knowledge in these instances was found to be synonymous with research and scientific evidence. The findings demonstrated that there is little scope in the current system for public health professionals who have the skills, expertise and knowledge to allow the use and adoption of an evaluation framework that is suited to the demands of current public health practice.

In particular, the organisational and political arrangements and structures in place do not allow for a critical evaluation of national programmes. In addition, the lack of formal mechanisms in place for staff to share information gained from local evaluations perpetuates the generation of meaningless information, which also prevents a better understanding of the implication of programmes for health outcomes. Demonstrating that a programme was being successfully delivered was the overriding requirement. The participants therefore made this their priority.

There needs to be recognition that not all programmes implemented can or will be successful. Therefore, there needs to be an acceptance that robust evaluation of programmes will not always yield positive results. This needs to be allowed to happen, as one benefit of understanding all aspects of a programme is to provide better understanding of what has become recognised and accepted as an essential part of public health practice and policy.

There also needs to be scope for public health practitioners at a local level to determine what information would be most useful for evaluation, as they may have a better understanding

of the context in which the programme is being delivered. This study demonstrated that public health practitioners do have an understanding that they have the professional duty to demonstrate that the programmes they are implementing are having an impact (Centre Disease Control 1999).

The themes that emerged from the study provided different and distinctive understandings of the nature of evaluation in practice. A key aspect to this research was the use of an ethnographic approach that allowed the researcher to use a mixture of methods to collect a rich body of data. This approach meant that the researcher was able to spend a significant amount of time in the setting working alongside the participant in their own environment. As a result the researcher become immersed in the setting and this yielded the insights about the practicalities of implementing and evaluating national programmes that may have not been possible with an approach in which this was not an integral aspect. Another key methodological factor that contributed to the findings was the use of a grounded theory analytical approach which was instrumental in enabling the researcher to develop the concepts and to conceptualise the relationships between the themes that were used to generate the final thematic framework.

This study provides a better understanding of the interconnection between data and information, and suggests that there needs to be a separation between the operational delivery of programmes and evaluation activities. Those who are involved in delivering a programme cannot also be expected to evaluate the programme. Expectation around evaluation needs to be made more explicit and should preferably be accompanied with explicit instructions. Importantly, evaluation needs to be promoted in a positive way and not as just a means of providing positive outcomes, but outcomes that improve understanding of programmes impact on health outcomes. The knowledge is derived from evaluation should then be used to determine which programmes are worth continuing with and those that need to be discontinued.

Until the contextual factors change this situation is likely to continue. The signs are not good however, as the political focus on the NHS, public health and the Health Check programme is greater than ever. The impact of the Health and Social Care Act in 2012 also needs to be taken into consideration as it has led to a number of significant changes in the healthcare system. These changes have created more layers of bureaucracy and additional reporting arrangements. Lines of accountability and

responsibility are even more unclear, exacerbating the problems with locating responsibility for robust evaluation of programmes at a local level. These changes have also had an impact on public health professionals who have been relocated into a number of different organisations outside of the healthcare system. This has led to a fragmented public health workforce and a loss of the key professional interactions and relationships necessary for production and translation of knowledge that this study found to be an essential aspect of evaluation in practice.

Due to the nature of the changes it is public health professionals who are going to experience the most disruption as they adapt to new organisational structures and cultures.

## **8.5 Strengths and limitations of the study**

Doing a qualitative study that drew on ethnographic and grounded theory analytical methods in an environment in which the researcher was familiar had significant practical value for facilitating recruitment, data collection and analysis. Importantly these approaches were good for developing a rapport and trust that was essential for doing a study that was exploring how participants perceived and understood evaluation in the context of their working environment.

The strength of this research was the use of a range of ethnographic approaches to collect the data and therefore increasing the credibility of the finding (LeCompte and Goetz 1982). Each of the approaches used in this study provided a different set of insights about evaluation. The interviews, the primary data collection method, gave insider insights, as the participant's willingness to talk openly about their views. This proved to be an effective approach to gain insights and understanding of how evaluation was perceived by participants. Working alongside public health and health professionals for a period of 18 months as a participant observer offered a good opportunity to explore how public health professionals perceived and carried out evaluation in a primary care setting. This enabled the researcher to be in a position to more accurately record the daily realities of the participants. Participant observation was an important method in this study because it provided insights about how evaluation which contributed to understanding of difference between how evaluation was conceptualised and how evaluation was carried out in practice.

The use of grounded theory analytical methodology provided a systematic approach to data analysis. The constant comparative cyclical approach of coding and comparing themes helped to ensure that they were developed from that data (Glaser 1965).

This study only explored evaluation from the perspective of one group of professionals. The findings of this research are from a one group of public health professionals involved in delivering one programme. Therefore it is likely the findings do not represent the full range of views about evaluation that exist. It is also possible that professionals from other organisations and professional groups could have different perspectives of evaluation. In addition participants were aware that they were being observed and knew the researcher and this may have influenced how they presented their views about evaluation.

This study was done during a time of uncertainty and change within the organisation. Participants were unsure of their future and what their roles and responsibilities would be in the new organisation. Some of these anxieties were expressed during the interviews and the group's meetings. It is likely that some of these anxieties and concerns may have influenced how evaluation of the health check programme in particular was perceived at this point in time. Concerns and the lack of security about jobs and position in the new organisation may have heightened need to be compliant with the requirements to demonstrate programmes they were involved with were working.

## **8.6 Researcher reflections**

Reflexivity is an important aspect of qualitative studies such as this one in which the researcher spends a long time in a field setting interacting with the participants. Reflexivity embodies the strategies that the researcher uses to filter their views and beliefs while engaged in investigating the social world of others (Bryman 2012). Reflecting on some key issues provides insights about the impact of certain situations on the researcher's actions, values and beliefs while involved in the research process.

Being a participant observer in a familiar environment working alongside participants who in the past were work colleagues, was both rewarding and challenging. Most of the challenges were related to getting used to being in a different role and being accepted as a researcher instead of a colleague. It was not easy to maintain the level of objectivity that was required as a



researcher at all times. As the researcher became a more integral member of the group and it was unrealistic as a participant observer with an active role and not engage in discussions and give opinions about the delivery and evaluation of the Health Check programme.

Bernard (2002) explains, participant observation is part of the humanistic tradition in which subjectivity is a core concept, in which insights into the human experience can be gained through the "use of your own feelings values and beliefs" (Bernard 2002:21). There is a danger of becoming too embedded in the environment and lose the research perspective. These are some of the issues that are raised by about "going native" (LeCompte and Goetz 1982). They explain that researchers who intend to spend a long time in the field need to be aware of the impact that this may have on their actions and interpretations of their findings. The researcher therefore needs to be reflective, keeping a research diary and recording feelings and accounts of the research reactions to situations are all part of the research and data collection strategy. The main disadvantage is maintaining objectivity and not becoming too immersed and losing the researcher outside perspective, this is a common concern with studies in which the researcher is an insider (Labaree 2002). The researcher made an effort to enter the setting without preconceived ideas about evaluation or how it should or should not be described. This was not easy as participants did see the researcher as someone who had a good knowledge and understanding of the principle and approaches of evaluation. The researcher keep a diary and recorded her views and reactions while engaging

It is also necessary to reflect on how participants responded to the researcher as a participant observer with an active role as a member of the CVD task group. The researcher was aware that her background, knowledge and skills could be a potential issue if asked to be involved in activities that might have an impact on the research findings. This would have put the researcher and the participants in difficult positions and potentially affecting the relationships. This reluctance to take on tasks that involved evaluating the programme was the researcher being concerned about influencing what was happening with evaluation in practice. It was agreed beforehand that the researcher would be given tasks that were not strategic in nature or ones that would influence what was being done with regards to evaluation of the health check programme. It was also agreed that the researcher would support activities related to evaluation instigated by the CVD task group. Some members of the task group did find it difficult to accept the researcher in another capacity and in particular one that was outside of what she was previously doing. The senior manager for example, did not like to ask the researcher to do tasks that she perceived as not suitable for the researcher to do such as general administrative tasks.

Even though it was agreed at the onset of the field work that these were the type of tasks that the researcher would do to assist with the delivery of the programme.

There was a gradual disengagement with activities relating the health check as to the abolition of the PCT came closer. Most of the conversations were about the impending move to the local authority in the latter stages of the field work period and less about the evaluation of the Health Check programme. There was a gradual winding down of the group as members moved to other departments and took on new roles. There was an air of resignation that things were changing again. Those still involved in the delivery of the programme were having to this in an environment that was very different from the one that they were used to. The public health team still remained together and in many ways the only things that would be changing were the organisational structures and arrangements, as most of the activities relating to the delivery of the Health Check programme were remaining the same. The necessary actions that a researcher would take to exit the field that would normally take place in a study in which the researcher had spent a long period of time with the participants did not happen. The exit from the setting was a gradual withdrawal because organisational change and the researcher's exit did not have an impact on the relationships as participant were also moving onto new roles and responsibilities.

#### **8.6.1 Maintaining anonymity of participants**

Maintaining anonymity was another area that required some reflection. It was important to consider what measures needed to be taken to protecting the identity of the participants. Maintaining anonymity was one of the conditions that relates to the protection of an individual's identity. Anonymity was maintained by not linking information obtained from a particular individual to that individual, particularly when it may lead to embarrassment or distress (Wiles 2006). Due to the nature of the study, anonymity of the participants who agreed to take part could not be fully guaranteed. The setting in which the study was taking place was one factor, as the researcher had previously worked in the organisation. The participants were a small and distinct group. Participants were aware that it was not going to be fully possible for them and the organisation to be unidentifiable in the final report

The researcher took extra measures to ensure that any data that was deemed as commercially sensitive, or was not directly related to evaluation, was not included in the analysis. In the final report the descriptions of the organisation and the participants were not in great

detail, only in enough detail to provide an understanding of the structures and arrangements that were in place. In the final report it was necessary to ensure that only information strictly related to the research topic was included in the analysis. It is recognised in studies in which the participants are part of a small distinct group that this is a common problem (Murphy et al.1998)

Some of the solutions proposed to preserve the anonymity of participants included letting participants review and verify material during the data collection and analysis phases of the research (Murphy et al. 1998, Associations of Social Anthropologist of the UK and the Commonwealth 1999). Other suggestions were to allow participants decide how material they feel may reveal their identity could be treated in the final report, or seeking consent that material that may reveal their identity could be published. Due to the nature of the study the researcher made it clear to potential participants that all attempts would be made to preserve their identity. The researcher's known association with the organisation made it was impossible to guarantee this to. It was explained to all participants before they agreed to become involved that the researcher would use all reasonable measures to try to ensure their identity was protected.

The measures taken to protect the identity of participants included the following:

- Interviews were transcribed by an external transcriber who was employed by the university.
- Personal information and names of locations would not be included in the final report or any other published material.
- Each participant had been given an anonymous code as they entered the study to be used for the duration of the study.

The consensus view was that it was unlikely that things that were being said would be controversial or would require full anonymity. It was agreed that if there something was considered controversial or would cause harm or distress to others it would not be included in the final report.

## 8.7 Conclusions

Public health professionals appear to be operating in a system in which robust evaluation at a local level is seen to be neither encouraged nor supported. There appears to be complicity at all levels in the NHS to show positive results, and public health professionals may be failing to use their professional autonomy because they are not given the necessary support to robustly evaluate public health programmes that politically driven. The lack of robust evaluation being carried out in a primary care trust environment was not due to the lack of evaluation frameworks, skills, knowledge or resources, but of a lack of willingness to take responsibility for the potential negative consequences of a robust evaluation process. This was reflected in participants' avoidance of responsibility to evaluate the programme at a local level.

Importantly, there needs to be recognition that a significant aspect of evaluation in practice is reliant on intangible outputs that are retained between the public health professionals. This intangible resource is the embedded knowledge that is key resource participants share and use to make assessment about the worth of programme they are involved with and to determine their response to political and organisational pressure to demonstrate success.

The findings from this study suggest that a system wide change is necessary so that public health professionals are not restrained by requirements to demonstrate positive outcomes and evaluation output that are designed to meet political and organisational obligations. In addition there is a need for the development of evaluation frameworks and approaches that take into account the multi-faceted nature of public health programmes and the way the professionals work at a local level to deliver programme.

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[Accessed Oct 2010]

## Appendix 1: Participants research information and consent forms

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The  
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**Penelope Siebert**

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Participant information sheet

Date 13<sup>th</sup> September 2011

**Research title: An exploration of evaluation from the perspective of professionals in a NHS service environment.**

### **Introduction**

As a PhD researcher at the University of Sheffield, I would like to invite you to take part in the above study, supervised by Professor Elizabeth Goyder.

Before you decide if you would like to take part, I would like to explain why the research is being carried out and what it would involve. I would be grateful if you could read the following information and discuss it with colleagues before you decide if you wish to be involved in the research. If you would like more information, please feel free to ask me (Penelope Siebert contact details above). Alternatively, if you are worried about being involved and you would like to discuss with a person independent of the research, please contact xxxx. Please take as much time as you need to decide whether or not you wish to take part.

### **The study:**

The research project will be exploring evaluation practice in a working environment in the context of the NHS Health Check Programme for cardiovascular disease. Very few studies were found that

explored evaluation from the perspective of professionals in a NHS primary care environment. This study aims to achieve an in- depth understanding of how staff who are implementing health programmes perceive and conduct evaluations while working within a primary care setting. It will also explore what processes and approaches are used to evaluate programmes and what factors may inhibit or promote evaluation. The research will be carried out as a qualitative field study, in which a mixture of methods, such as participant observation, semi-structured interviews, review of documents and field notes will be used to collect data. This research is being done in collaboration with xxx PCT who has funded the PhD studentship for the research. The research and will take place in xxx offices and meeting rooms and will be carried out from September 2011 to March 2013.

### **Who would be involved?**

Ideally I would like all those who are involved in the delivery and evaluation of the NHS Health Check programme for cardiovascular disease (CVD) to agree to be involved in the participant observation arm of the study, and the informal discussions this may include. Staff who have a substantial role in delivering and evaluating the NHS health check programme will be invited to take part in semi-structured interviews.

### **What would I have to do if I chose to take part?**

If you agree to take part, it would mean allowing me to observe, shadow you and make notes of your everyday work activities and asking questions for clarification during observations. I will sometimes use a digital recorder during formal and informal meetings relating to evaluation and the implementation and evaluation of the NHS Health Check programme. You would be asked to sign a study consent form at the beginning of the study. After which your consent will be assumed with your agreement unless you indicate otherwise. I will always inform you when my observations are for research purposes. You will not be expected to participate in the study each day that you are in at work.

A further part of the study would include semi-structured interviews with staff, focusing on perceptions and attitudes to evaluation. Interviews would be recorded, but only with the permission of individuals. The interviews would follow an interview topic guide. These interviews will be recorded and carried out at work, in a quiet private room, at a time convenient to you and will last approximately 45–60 minutes. You may be asked to consider taking part in 2 to 3 follow up interviews as new themes emerge.

The final part of the study involves the researcher analysing formal and informal public documents such as policies, guidance and other relevant written work and minutes of meetings.

### **How will the recorded media be used?**

A digital recorder will be used to record formal and informal meetings and semi-structured interviews. No one outside the research team will be allowed access to the original recordings. Your consent will be gained before recordings take place. The audio files on the device will be encrypted and transferred as soon as possible to a computer and stored as a password protected

file until it is transcribed. Audio recordings will be transcribed verbatim as soon as possible after being recorded by a professional transcriber employed by the University of Sheffield. Original recordings on the audio device will be securely erased after transcription. A code will be assigned to you when you agree to take part which will be used during data collection, analysis and in any published reports, articles and PhD thesis. Your name and corresponding code will be kept on a password protected file and stored on a University of Sheffield computer.

### **Will my taking part in this project be kept confidential?**

As the researcher I will be responsible for ensuring, when collecting and analysing the data that I am not contravening legal or regulatory requirements in the UK in regards to confidentiality and data protection. All the information collected during the course of the research will be kept strictly confidential. Your identity and all views expressed and actions observed will remain anonymous in all the analysis and reporting of the research. All responses would be confidential and all attempts will be made to maintain anonymity in the publication of results.

### **What will happen to the results of the research project?**

The research results will be published and presented both in scientific journals and at scientific meetings, so as to reach the widest possible audience. All identifiable information will be removed or replaced by a pseudonym in published material and in the final PhD thesis. Participants will be given a summary report of the research and offered a copy of the final PhD Thesis.

### **Do I have to take part?**

It is up to you to decide whether or not to take part in the study. If you would prefer not to take part you do not have to give a reason. If you decide to participate, you are free to withdraw from the study at any time, without having to provide an explanation. You will be provided with the contact details of an independent person with whom you can confidentially discuss any concerns that you may have about the research.

If you decide to take part you would be asked:

- A) To give written consent for participant observation (I will check with you for verbal consent before each observation);
- B) To give written consent for recording of meetings. (I will ask for verbal consent before undertaking any audio recordings of informal or formal meetings)
- C) To give written consent for recording of semi-structured interviews
- D) To give consent for relevant documents including minutes of meetings to be read

You will be given copies of this information sheet and the signed consent forms to keep.

**What do I do now?**

I would be grateful if you would discuss this invitation with your colleagues before deciding to take part. In the meantime, if you would like any questions answered to help you make your decision, please do not hesitate to contact me on the details above.

Thank you for considering taking part in this research.



### STUDY CONSENT FORM.

**Title of Project:** An exploration of evaluation from the perspective of professionals in a NHS service environment.

**Name of Researcher:** Penelope Siebert

Please initial the box after each statement:

1. I confirm that I have read and understand the "Participant Information Sheet" dated 13 September 2011 (version 2) for the above study. I have had the opportunity to consider the information, to ask questions, and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary, and that I am free to withdraw at any time, without giving any reason, and without my employment or legal rights being affected. ☐
3. I understand and agree that I will be observed and the researcher will be shadowing me during my everyday work activities and will be attending and recording meetings. ☐
4. I understand and agree that documents and minutes of meetings will be read. ☐
5. I understand and agree to take part in at least one in-depth interview. ☐
6. I understand that the information collected will be kept anonymous. ☐
7. I understand that excerpts of the interview and meetings may be used for research purposes, which includes being part of a PhD thesis, and publication in professional journals. ☐
8. I agree to take part in the above study. ☐

.....	.....	.....
Name of Participant	Signature	Date
.....	.....	.....
Researcher	Signature	Date

## Interview Topic Guide

**Research Title:** An exploration of evaluation from the perspective of professionals in a NHS service environment.

**Researcher Name:** Penelope Siebert

Guide for semi-structured interviews with staff involved in delivering and evaluating the NHS health check programme.

### Understanding how evaluation is perceived

What does the term evaluation mean to you?

How would you define evaluation?

What is the purpose of evaluation?

### How is evaluation done in practice?

What methods and approaches would you use to assess a programme that you are involved in delivering?

### Understanding attitudes to evaluation

Who is responsible for evaluating health programmes?

What are you most interesting in finding out when you evaluate a programme?

In your view information from an evaluation is important?

### Experiences of evaluation

Can you tell me about some of your experiences of being involved in or conducting an evaluation?

Is there anything you would like to add?

## **Appendix 2: Agenda for change job Statements Summary**

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### **Staff at band 6**

#### **Public Health Researcher**

Job Statement:

1. Monitors and develops public health research activity within NHS.
2. Designs, conducts, analyses and disseminates research findings and reports.
3. Advises on and monitors research conducted by other health professionals.

#### **Health Improvement Practitioner Specialist**

Job Statement:

1. Contributes to, and advises on the development and implementation of specialist local health improvement programmes.
2. Develops and maintains public health information and support structures.
3. Facilitates/ leads multi-agency public health group work and community based health needs assessment; implements monitoring and evaluation mechanisms to assess the impact of community action on health.
4. Provides training to a range of staff and community groups.

### **Staff at band 7**

#### **Health Improvement Practitioner Advanced**

Job Statement:

1. Contributes to and advises on the development and implementation of specialist local health improvement programmes, evaluates effectiveness.
2. Promotes public involvement in planning, development, implementation and evaluation of public health improvement activities.
3. Facilitates multi-agency public health group work and community-based health needs assessment.
4. Supervises public health staff; may manage public health staff.

### **Staff at band 8**

#### **Public Health Consultant**

Job statement:

1. Interprets national, regional and local policies to develop inter-agency and interdisciplinary strategic plans and programmes, with delegated Board authority to deliver key public health targets
2. Provides public health advice to support and inform an evidence-based approach within ethical frameworks for commissioning and developing services, including both primary and secondary care, across sectors including local authorities, voluntary organisation.
3. Develops major information and intelligence systems to support public health information across disciplines and organisations.
4. May commission research audits /projects.
5. May manage a team of staff or develop training programmes; may train public health trainees

Source: Agenda for change National Job profiles

<http://www.nhsemployers.org/your-workforce/pay-and-reward/pay/job-evaluation/national-job-profiles>

**Appendix 2: Example open coding themes coding table**

<b>Data from Interviews</b>	<b>Open Code</b>	<b>description</b>	<b>memo</b>
I suppose whoever, who is involved with the project need to <b>have a collective view</b> of, that evaluation is important,	collective action	shared view about the importance of evaluation	What seems to be important is a collective approach about where evaluation sits in the bigger scheme of things.
the lead is, for that project should be responsible or that lead is delegated to someone on the project group who's doing it, to be responsible for evaluation, but someone should carry that label of responsibility.	someone needs to be responsible	responsibility is not assumed	<b>Responsibility</b> is assigned but no sense that it is a role that is taken on, it is interesting that the person who is saying this is the lead for the project but in a way has distanced themselves for this fact
I suppose we've I suppose <b>evaluated the programme</b> as we've gone along because we didn't have the guidance initially	ongoing	self directed action	
We didn't I didn't set it up right at the start of the service because the thing what we need is some feedback from people who've been through the system.	not doing evaluation	Reasons not to evaluate	Delaying due to time factors given as an excuse as to why evaluation was not being done.
Well it means we'd be looking at the monitoring and seeing if it was cost effective. And we will be doing a patient satisfaction survey. I need to set that up.	thinking of doing	Intention to evaluation expressed	There is a desire to assess the programme somehow, evaluation in this example involves looking and seeing what is going on but this in not an informal way there was not mentions of a plan they are all practical approaches. This forms evaluation as it is doing something with the information already there and thinking about the process of getting more

			information
straight away the first thing that happens is a massive debate and a massive argument about how the data's been derived, how the data's been calculated, how it's been analysed, how it's been presented, what's been included, what's been excluded,	Checking the data	interactive collective process related to the data and what and how it should be represented.	Exchanging views and thoughts about the data and its value or quality, in this example data is being valued and described at the same time. in what form data is presented seems to be important
I think there's an aversion to <b>doing the evaluation</b> because if it shows something that people don't like,	Negative	Reasons to avoid doing evaluation	some insight about how evaluation is viewed in a negative way.

Appendix 3: Example data coding table developing the themes

Data from Interviews	Open Code	Properties and dimensions	themes
I suppose whoever, who is involved with the project need to <b>have a collective view</b> of, that evaluation is important, and I suppose if you're looking for an individual who is responsible, who are, <b>the lead is for that project should be responsible</b> or that lead is delegated to someone on the project group who's doing it, to be responsible for evaluation, but <b>someone should carry that label of responsibility</b> .	Distancing	Not assuming responsibility	Avoiding responsibility
Well it means we'd be looking at the monitoring and seeing if it was cost effective. And we will be doing a patient satisfaction survey. <b>I need to set that up</b> . We didn't <b>I didn't set it up right at the start of the service because the thing what we need is some feedback from people who've been through the system</b> .	waiting	talking about the process, postponing	Deferring
I think there's an aversion to doing the evaluation because <b>if it shows something that people don't like</b> , it's the same when the SHA and PCT are having performance conversations about public health, we take particularly like we've taken the QAF data for example and looked at the level of disease prevalence versus the expected, and straight away <b>the first thing that happens is a massive debate and a massive argument about how the data's been derived, how the data's been calculated, how it's been analysed, how it's been presented, what's been included, what's been excluded, and everyone gets so bogged down in that because it's so easy then to make the data look the way you want it to look you never actually get to the nitty gritty of what the problem is</b> .	inability to agree	competing perspectives, deflecting discrediting	Excusing

#### Appendix 4: Notes from researcher diary

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##### Sample of memos written during the open coding phase.

The process of evaluation is described in terms of being **formal and informal**. The formal evaluation is described as the form of evaluation that is specifically requested and this is one that is in the form of a document or report.

The **informal evaluation** is the ones that goes on in your head, it is an everyday activity, the cornerstone what members of the public health team do, assessing a programmes progress, its impact in terms of not upsetting anyone or imposing things on them and the level of activity and making sure quality is maintained.

participants have made a this **distinction between formal and informal** but have not used these terms but it is talked about in terms of pulling thoughts together, writing down what I know has worked from what I have seen.

It would seem that **informal evaluation** or the process that are used to determine what is going on and how things are progressing are based primarily on tacit knowledge. Looking at it in terms of this being a culture it appears to have its own set of criteria which dictate how the information is valued.

**Reflection** is a key part of the process, and this is a key aspect of processing knowledge that is tacit

It can be said these are all socially derived or developed interactions and looking more at the data would help me to explore or find out more about how these develop and are maintained. These are all socially derived and easiest within a social system or culture that is based on trust and tacit knowledge that tacit knowledge element determines the status of the provider of the informational the story there is a view that experiences giving the individual the accumulated knowledge over the time.



## Appendix 6: Extracts: PCT material

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Instructions for data that needed to be collected for monitoring and evaluation of the programme draft paper distributed to the practices prepared by the CVD task group.

### Information needed from Practices (DRAFT):

#### Baseline

Number of 40-74 year olds registered with the Practice, numbers excluding diabetics and existing CVD.

Number of patients for whom CVD risk can be calculated and already have known CVD risk >20% - the current CVD high risk register

Number of full face to face CVD risk assessments (clear definition to be provided) carried out and still valid (in last 15 months?) in 40-74 year age group

Number of people on Hypertension register (40-74 years) including those with a CVD risk score >20%

*QOF: Number of patients with a new diagnosis of hypertension recorded between the preceding 1<sup>st</sup> April and 31<sup>st</sup> March – who have had a full face to face CVD risk assessment*

Number of people on Obesity register / Number of people with BMI recorded in last 15 months

Number of people with BMI >25/ 30/35

Number of diabetics

Number of smokers

Number of 4 week smoking quitters

Number patients identified as 'hazardous and harmful drinkers'

#### Routine/Monthly reports

Number of 40-74 year olds registered

Number of newly diagnosed hypertensive patients since last report

Number of full face to face CVD risk assessments carried out since last report (breakdown by age, gender, postcode, ethnic group)

Number of people (40-74 yrs) with >20% 10 year CVD risk (excluding diabetics, those with CVD, etc.)

Number of new recorded BMI's

Number of obese patients with CVD risk of >20%

Number of people referred to Motivational Support Programme, Fresh Start, Alcohol services, etc.

Prescribing data?

(CVD task group extract from minutes of meeting discussing data collection from practices )

## **Extract from annual report 2011 prepared by CVD task group**

### **Monitoring and Evaluation of the Programme**

Individual practice programme uptake and referrals for 2010/11 (from the paper monitoring forms submitted) was provided (these have already been sent out to HCAs in the minutes of their meeting in May. Details of their target number of invites / Health Checks also included. 20% (1/5<sup>th</sup>) of the total eligible population need inviting in each year from April 2012 as it is a 5 yearly programme. SOP target for this year is 18% of the total eligible population need inviting in each year.